LIMITED SCOPE MARKET CONDUCT EXAMINATION REPORT
AS OF DECEMBER 31, 2008

WORLD INSURANCE COMPANY
11808 Grant Street
Omaha, NE 68164

NAIC #: 70629
NAIC Group Code: 3527

CONDUCTED BY:

COLORADO DIVISION OF INSURANCE

WORLD INSURANCE COMPANY
11808 Grant Street
Omaha, NE 68164

LIMITED SCOPE MARKET CONDUCT EXAMINATION REPORT
as of
December 31, 2008

Prepared by:

State Market Conduct Examiners

Jeffory A. Olson, CIE, FLMI, AIRC, ALHC

Damion Hughes

And

Independent Contract Examiner

Howard Quinn CCP, AIE, CLU, ChFC

April 20, 2010

The Honorable Marcy Morrison
Commissioner of Insurance
State of Colorado
1560 Broadway Suite 850
Denver, Colorado 80202

Commissioner Morrison:

A limited scope market conduct examination of World Insurance Company was conducted pursuant to §§ 10-1-201, 10-1-203, 10-1-204, 10-1-205(8), 10-1-212, 10-1-213, and 10-3-1106, C.R.S., which authorize the Insurance Commissioner to examine insurance companies. The examination was conducted at the Division of Insurance, located at 1560 Broadway Suite 850 Denver, Colorado 80202, and at the home office of the independent examiner, located in Arizona.

The examination covered the period from January 1, 2008 through December 31, 2008, and included a review of the Company's operations and management, contract forms, claim handling, utilization review, and the issues identified during Colorado's 2003 market conduct examination of this Company.

The following market conduct examiners respectfully submit the results of this examination.

Jeffory A. Olson, CIE, FLMI, AIRC, ALHC
State Market Conduct Examiner

Damion Hughes
State Market Conduct Examiner

Howard Quinn CCP, AIE, CLU, ChFC
Independent Market Conduct Examiner

**MARKET CONDUCT
EXAMINATION REPORT
OF
WORLD INSURANCE COMPANY**

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COMPANY PROFILE

The following profile is based on information provided by the Company:

World Insurance Company (World) has been active in the Colorado market for more than 70 years, establishing its first general agency in the state on May 4, 1938.

Originally incorporated on October 1, 1903, as an assessment association under the title of World Accident Association, the present title was adopted in 1929. In April of 1997, MidAmerica Mutual Life Insurance Company was merged into World Insurance Company. In December of 2003, World was converted to a stock company through the course of a mutual holding company reorganization. World then became a part of the American Enterprise Group (AEG) when World Mutual Holding Company, the owner of World, was merged into American Republic Mutual Holding Company on January 13, 2004.

The vast majority of World's operations are concentrated in the individual accident and health market, where it primarily offers major medical plans. Although the majority of World's major medical premium revenue growth over the past decade has resulted from acquisitions, the company has recently been concentrating on organically growing this book of business via an expansion of sales territories and agents. The company currently markets individual major medical products through independent marketing organizations (IMOs) and managing general agents (MGAs).

World is licensed in 48 states, and is domiciled in the state of Nebraska. States currently generating the largest direct premium revenue volumes are Colorado, Texas, Montana, North Carolina, and Georgia.

In 2008 the Company's Individual Accident and Health direct written premium in Colorado was $21,764,000, representing a 2.08% share of the market. The Company also reported a loss ratio of 55.12%, in 2008, related to their Colorado Individual Accident and Health business. As of April 2010 the Company was assigned an A. M. Best financial strength rating of A- (Excellent), and was also assigned the Financial Size Category of Class VIII.

PURPOSE AND SCOPE OF EXAMINATION

State market conduct examiners with the Colorado Division of Insurance (Division), who were assisted by an independent contract examiner, reviewed certain business practices of World Insurance Company. This limited market conduct examination was conducted in accordance with Colorado insurance laws, §§ 10-1-201, 10-1-203, 10-1-204, 10-1-205(8), 10-1-212, 10-1-213, and 10-3-1106, C.R.S., which empower the Commissioner to examine any entity engaged in the business of insurance. The findings in this report, including all work products developed in producing it, are the sole property of the Division.

The purpose of the limited examination was to determine the Company's compliance with Colorado insurance laws related to sickness and accident insurance plans for individuals. Examination information contained in this report should serve only these purposes. The conclusions and findings of this examination are public record. The preceding statements are not intended to limit or restrict the distribution of this report.

The examiners conducted the limited examination in accordance with procedures developed by the Colorado Division of Insurance, based on model procedures developed by the National Association of Insurance Commissioners. In reviewing material for this report the examiners relied primarily on records and materials maintained and/or submitted by the Company. The market conduct examination covered a twelve (12) month period from January 1, 2008 through December 31, 2008, and included a review of the following:

1. Company Operations and Management
2. Contract Forms
3. Claim Handling
4. Utilization Review
5. Review issues identified in the 2003 Colorado examination

Upon review of each targeted area any concerns or discrepancies were noted on comment forms and delivered to the Company for review. Once the Company was advised of a finding contained in a comment form, the Company had the opportunity to respond. For each finding, the Company was requested to agree, disagree or otherwise justify the Company's noted action. At the conclusion of each review, the Company was provided a summary of the findings related to each targeted area. The examination report is a report by exception. Therefore, much of the material reviewed is not addressed in this written report. References to any practices, procedures, or files which manifested no improprieties were omitted.

An error tolerance level of plus or minus ten dollars ($10.00) was allowed in most cases where monetary values were involved. However, in cases where monetary values were generated by computer or other systemic methodology, a zero dollar ($0) tolerance level was applied in order to identify possible system errors. Additionally a zero dollar ($0) tolerance level was applied in instances where there appeared to be a consistent pattern of deviation from the Company's established policies, procedures, rules and/or guidelines.

Sample sizes were chosen based on procedures developed by the National Association of Insurance Commissioners. When sampling was involved, a minimum error tolerance level of seven percent (7%) for claims, and ten percent (10%) for all other samples, was established to determine reportable exceptions. However, if an issue appeared to be systemic, or when due to the sampling process it was not feasible to establish an exception percentage, a minimum error tolerance percentage was not utilized. Also, if more than one sample was reviewed in a particular area of the examination (e.g. timeliness of claims payment), and if one or more of the samples yielded an exception rate higher than the minimum tolerance level, the results of any other samples with exception percentages less than the minimum tolerance were also included.

Certain unacceptable or non-complying practices may not have been discovered in the course of this examination. Additionally, findings may not be material to all areas that would serve to assist the Commissioner. Failure to identify or criticize specific Company practices does not constitute acceptance of such practices by the Division. Examination findings may result in administrative action by the Division.

A copy of the Company's official response to this final market conduct report, if applicable, can be obtained upon request from the Division.

Results of previous market conduct examinations are available on the Division's website at www.dora.state.co.us/insurance or by contacting the Division.

EXAMINERS' METHODOLOGY

The examiners reviewed the Company's business practices to determine compliance with Colorado insurance laws and Colorado regulations. For this examination, special emphasis was given to the laws and regulations as shown in Exhibit 1.

Exhibit 1

Law/Regulation	Subject
Section 10-1-128, C.R.S.	Fraudulent insurance acts – immunity for furnishing information related to suspected insurance fraud – legislative declaration.
Section 10-3-1104, C.R.S.	Unfair methods of competition and unfair or deceptive acts or practices.
Section 10-16-102, C.R.S.	Definitions.
Section 10-16-104, C.R.S.	Mandatory coverage provisions – definitions.
Section 10-16-104.3, C.R.S.	Dependent health coverage for persons under twenty-five years of age.
Section 10-16-104.5, C.R.S.	Autism – treatment – not mental illness.
Section 10-16-104.7, C.R.S.	Substance abuse – court-ordered treatment coverage.
Section 10-16-104.8, C.R.S.	Mental health services coverage – court-ordered.
Section 10-16-105.5, C.R.S.	Individual health plans – federally eligible individual – limited guarantee issue.
Section 10-16-106.3, C.R.S.	Uniform claims – billing codes – electronic claim forms.
Section 10-16-106.5, C.R.S.	Prompt payment of claims – legislative declaration.
Section 10-16-106.7, C.R.S.	Assignment of health insurance benefits.
Section 10-16-107, C.R.S.	Rate regulation – rules – approval of policy forms – benefit certificates – evidences of coverage – benefits ratio – disclosures on treatment of intractable pain.
Section 10-16-107.2, C.R.S.	Filing of health policies.
Section 10-16-113, C.R.S.	Procedure for denial of benefits– rules.
Section 10-16-113.5, C.R.S.	Independent external review of benefit denials – legislative declaration – definitions.
Section 10-16-118, C.R.S.	Limitations on preexisting condition limitations.
Section 10-16-123, C.R.S.	Telemedicine.
Section 10-16-125, C.R.S.	Reimbursement to nurses.
Section 10-16-201, C.R.S.	Form and content of individual sickness and accident insurance policies.
Section 10-16-201.5, C.R.S.	Renewability of health benefit plans – modification of health benefit plans.
Section 10-16-202, C.R.S.	Required provisions in individual sickness and accident policies.
Section 10-16-203, C.R.S.	Optional provisions in individual sickness and accident policies.
Section 10-16-204, C.R.S.	Inapplicable or inconsistent provisions in individual policies of sickness and accident insurance.
Section 10-16-205, C.R.S.	Order of certain policy provisions in individual policies of sickness and accident insurance.
Section 10-16-208, C.R.S.	Conforming to statute.
Section 10-16-209, C.R.S.	Application for policy.

Section 10-16-211, C.R.S.	Age limit.
Section 10-16-219, C.R.S.	Benefits for care of mental illness or retardation in tax supported institutions.
Section 10-16-704, C.R.S.	Network adequacy – rules – legislative declaration – repeal.
Section 10-16-705, C.R.S.	Requirements for carriers and participating providers.
Insurance Regulation 1-1-6	Concerning the Elements of Certification for Accident and Health Forms, Private Passenger Automobile Forms, Commercial Automobile with Individually-Owned Private Passenger Automobile-Type Endorsement Forms, Claims-Made Liability Forms, Preneed Funeral Contracts and Excess Loss Insurance in Conjunction with Self-Insured Employer Benefit Plans under the Federal "Employee Retirement Income Security Act"
Insurance Regulation 1-1-7	Market Conduct Record Retention
Insurance Regulation 1-1-8	Penalties and Timelines Concerning Division Inquiries and Document Requests
Insurance Regulation 4-2-1	Replacement of Accident and Sickness Insurance
Insurance Regulation 4-2-5	Hospital Definition
Insurance Regulation 4-2-6	The Definition of the Term "Complications of Pregnancy"
Insurance Regulation 4-2-8	Concerning Required Health Insurance Benefits for Home Health Services and Hospice Care
Insurance Regulation 4-2-13	Mammography Minimum Benefit Level
Insurance Regulation 4-2-16	Women's Access to Obstetricians, Gynecologists, and Certified Nurse Midwives Under Managed Care Plans
Insurance Regulation 4-2-17	Prompt Investigation of Health Plan Claims Involving Utilization Review and Denial of Benefits
Insurance Regulation 4-2-18	Concerning the Method of Crediting and Certifying Creditable Coverage for Pre-Existing Conditions
Insurance Regulation 4-2-19	Concerning Individual Health Benefit Plans Issued to Self-Employed Business Groups of One
Insurance Regulation 4-2-21	External Review of Benefit Denials of Health Coverage Plans
Insurance Regulation 4-2-24	Concerning Clean Claim Requirements for Health Carriers

Company Operations/Management

The examiners reviewed the Company's management, Certificate of Authority, Access Plan, anti-fraud plan procedures/implementation, and their timely cooperation with the examination process.

Contract Forms

The examiners reviewed the following contract forms, endorsements, and disclosure forms in use during the exam period for compliance with the appropriate statutes and regulations:

FORM NUMBER	FORM NAME
A4024	Catastrophic Major Medical-PPO High Deductible
A4024	Catastrophic Major Medical-Non-PPO HSA
A4024	Catastrophic Major Medical-PPO HSA
A4024	Catastrophic Major Medical-PPO HSA with Optional Benefits
A4024	Comprehensive Major Medical-PPO High Deductible
A4024	Comprehensive Major Medical-Non-PPO HSA
A4024	Comprehensive Major Medical-PPO HSA
A4024	Comprehensive Major Medical-Non-PPO
A4024	Comprehensive Major Medical- PPO Plans
R1180-P	Wellness Benefit Rider
R1180	Wellness Benefit Rider
R1148	Outpatient Accident Benefit Rider
R1148-CO	Outpatient Accident Benefit Rider
R1144	Foreign Travel Benefit Endorsement
R1146-CO	Life Benefits for Insured Rider
R1147-CO	Life Benefits for Covered Spouse Rider
R1246	Refund of Premium for Good Health
R1153-ind.	Cancer Benefit Rider
A4800W-CO	Catastrophic Major Medical
A4800W-CO	Comprehensive Major Medical
R4800W-CO	Colorado State Mandated Benefits Rider
R4801W-I	Accident Expense Benefit Rider
R4802W-I	Accidental Death Benefit Rider
R4803W-I	Critical Illness Benefit Rider
R4804W-I	Decreasing Deductible Rider
R4805W-I	Premium Discount for Good Health Rider
R4806W-I	Refund of Premium for Good Health Rider
R4808W-I	Office Visit Benefit Rider
R4808W-I-1	Office Visit Benefit Rider
R4809W-I	Short Term Convalescent Care Rider
R4810W-I-CO	Outpatient Prescription Drug Benefit Rider
R4811W-I-CO	Outpatient Prescription Drug Benefit Rider
R4812W-I-CO	Outpatient Prescription Drug Benefit Rider
R4813W-I-CO	Outpatient Prescription Drug Benefit Rider
R4814W-I	Wellness Benefit Rider
R4815W-I	Maternity Expense Benefit Rider
R4816W-I	Term Life Insurance Rider
G4800W-CO	Application Form
G4800W-Eapp	Application Form
G4820W	Application Form
M1184W	Preferred Rating Guidelines/Questionnaire
A3601-CO (1-97)	Major Medical Policy
A3603-CO (1-97)	Major Medical Policy
A3604-CO (1-97)	Major Medical Policy
A3605-CO (1-97)	Major Medical Policy
A3606-CO (1-97)	Major Medical Policy
A2192-CO (1-99)	Short Term Major Medical Policy
A3800	Major Medical Policy

Claims

For the period under examination, the examiners randomly selected the following samples of claims for review to determine compliance with the Company's claims handling practices:

- One hundred nine (109) paid claims from a population of 60,367 claims received during the examination period.
- One hundred nine (109) denied claims from a population of 16,780 received during the examination period.

The above two samples were reviewed for overall claim handling and accuracy of payment.

- One hundred seven (107) electronic claims from a population of 5,002 electronic claims received during the examination period that were not paid denied or settled within thirty (30) days.
- One hundred five (105) non-electronic claims from a population of 680 non-electronic claims received during the examination period that were not paid, denied or settled within forty-five (45) days.
- One hundred seven (107) electronic and non-electronic claims from a population of 1,174 claims received during the examination period that had not been paid, denied or settled within ninety (90) days.

The above three samples were reviewed to determine the Company's compliance with Colorado's prompt payment of claims law.

Utilization Review

The examiners reviewed the Company's utilization review (UR) management program including policies and procedures. For the period of January 1, 2008 through December 31, 2008, the examiners reviewed the entire population of forty-nine (49) total UR decision files for compliance with statutory requirements, including:

- Forty-two (42) UR Approvals
- Six (6) UR Denials
- One (1) UR Appeal

Prior Examination

The examiners reviewed the areas of concern identified within the last market conduct exam of this Company, which was completed on June 11, 2004 covering the period of January 1, 2003 to December 31, 2003, to ensure compliance with the appropriate statutes and regulations.

EXAMINATION REPORT SUMMARY

The examination resulted in a total of thirty-seven (37) findings in which the Company did not appear to be in compliance with Colorado Statutes and Regulations. The following is a summary of the examiners' findings.

Company Operations and Management: In the area of company operations and management, no compliance issues are addressed in this report

Contract Forms: The examiners identified thirty-three (33) areas of concern in their review of the Company's contract forms.

Issue E1: **Failure to provide coverage to or on behalf of an insured because the insured or a covered dependent sustained an injury while intoxicated or under the influence of a controlled substance.**

Issue E2: **Failure, in some cases, to include or to completely include the required language related to contract changes within the Company's policy forms.**

Issue E3: **Failure, in some cases, to include the required one year timeframe regarding time limits on certain defenses.**

Issue E4: **Failure, in some cases, to include the mandatory language related to notice of claim.**

Issue E5: **Failure, in some cases, to include the mandatory language related to payment of claims.**

Issue E6: **Failure, in some cases, to include the mandatory language related to change of beneficiary.**

Issue E7: **Failure, in some cases, to include the mandatory language related to early intervention services.**

Issue E8: **Failure, in some cases, to provide complete benefits related to therapies for congenital defects and birth abnormalities.**

Issue E9: **Failure, in some cases, to provide coverage to stepchildren that do not permanently reside with an insured.**

Issue E10: **Failure, in some cases, to include the mandatory coverage provision, or to provide the required number of number of well-child visits, related to child health supervision services.**

Issue E11: **Failure, in some instances, to include the mandatory coverage for prosthetic devices.** *This appears to be a repeat issue that was identified as issue E8 during the last market conduct exam of this Company, which was completed on June 11, 2004 covering the period of January 1, 2003 to December 31, 2003.*

Issue E12: **Failure, in some cases, to include the mandatory coverage for cervical cancer vaccines.**

Issue E13: **Failure to offer coverage for dependents up to age twenty-five.**

Issue E14: **Failure to include the required disclosure regarding coverage for treatment of intractable pain.**

Issue E15: **Failure, in some cases, to include the appropriate definition of "Dependent" within the Company's policy forms.**

Issue E16: **Failure, in some cases, to provide coverage for services and/or supplies furnished by a member of a covered person's immediate family, employer, business partner, or a person who ordinarily resides in the covered person's home.** *This appears to be a repeat issue that was identified as issue E7 during the last market conduct exam of this Company, which was completed on June 11, 2004 covering the period of January 1, 2003 to December 31, 2003.*

Issue E17: **Failure, in some cases, to include the appropriate definition of "preexisting condition" in the Company's forms.**

Issue E18: **Failure, in some cases, to provide coverage for self-inflicted injuries, suicide, and attempted suicide to members that are insane.** *This appears to be a repeat issue that was identified as issue E5 during the last market conduct exam of this Company, which was completed on June 11, 2004 covering the period of January 1, 2003 to December 31, 2003.*

Issue E19: **Failure, in some cases, to provide coverage for procedures that have been preauthorized.**

Issue E20: **Failure, in some cases, to provide a clear indication of what is considered a complication of pregnancy and/or the complications of pregnancy definition included in the policy is overly restrictive.**

Issue E21: **Failure to provide a complete listing of forms within its annual certification of forms.**

Issue E22: **Failure to ensure that all forms certified by the Company were in compliance with Colorado insurance law.**

Issue E23: **Failure, in some cases, to provide coverage to newborns or children placed for adoption for the first thirty-one (31) days from the date of birth or placement unless premium is paid.**

Issue E24: **Failure, in some cases, to provide coverage related to any organ, system, or part/area of the body that the Company deems necessary.**

Issue E25: **Failure, in some cases, to provide coverage for services or treatment related to certain "high risk" activities.**

Issue E26: **Failure to specifically include the required coverage for newborn hospital stays.**

Issue E27: **Failure, in some cases, to include the mandatory coverage for inherited enzymatic disorders.**

Issue E28: **Failure, in some cases, to apply the appropriate timeframes related to when premium can be accepted in connection with a reinstatement, and to use the statutorily-mandated language as required.**

Issue E29: **Failure, in some cases, to clearly disclose the existence and availability of an access plan.** *This appears to be a repeat issue that was identified as issue E4 during the last market conduct exam of this Company, which was completed on June 11, 2004 covering the period of January 1, 2003 to December 31, 2003.*

Issue E30: **Failure, in some cases, to include the mandatory language regarding claim forms.**

Issue E31: **Failure to reflect the appropriate adjustments that are to be made when a misstatement of age or sex occurs.**

Issue E32: **Failure, in some cases, to include the mandatory coverage for hospitalization and general anesthesia for dental procedures for dependent children.**

Issue E33: **Failure, in some cases, to include the mandatory coverage for diabetes.**

Claims: The examiners identified three (3) areas of concern in their review of the Company's handling of claims.

Issue J1: **Failure, in some cases, to pay, deny or settle claims within the timeframes required by Colorado insurance law.**

Issue J2: **Failure, in some cases, to pay the appropriate penalty payment to the insured or health care provider on the ninety-first day after receipt of the claim by the carrier.**

Issue J3: **Failure, in some cases, to request specific additional information when the carrier's claim liability cannot be determined with the existing information on the claim form, and the information requested would likely allow determination of liability to be made.**

Utilization Review: The examiners identified one (1) area of concern in their review of the Company's utilization review procedures.

Issue K1: **Failure to include correct information in utilization review approval letters.**

WORLD INSURANCE COMPANY

FACTUAL FINDINGS

CONTRACT FORMS

Issue E1:	**Failure to provide coverage to or on behalf of an insured because the insured or a covered dependent sustained an injury while intoxicated or under the influence of a controlled substance.**

Section 10-16-201, C.R.S., Form and content of individual sickness and accident policies, states in part:

(6) An individual policy of sickness and accident insurance, other than a long-term care policy, disability income policy, or supplemental policy covering a specified disease or other limited benefit, issued, renewed, or reinstated on or after January 1, 2007, shall not contain any provision that limits or excludes payments under hospital or medical benefits coverage to or on behalf of the insured because the insured or a covered dependent sustained an injury while intoxicated or under the influence of a controlled substance, as defined in section 18-18-102(5), C.R.S.

It appears that the Company is not in compliance with Colorado insurance law in that its policy forms specifically exclude any loss sustained or contracted in consequence of the covered person's being intoxicated or under the influence of any narcotic, unless administered on the advice of a physician, and any injury or illness sustained by voluntary use of illegal drugs or hallucinogenics.

The Company's A4204 policy forms state, in part, the following:

General Exclusions and Limitations

This policy does not cover:

- Any loss sustained or contracted in consequence of the covered person's being intoxicated or under the influence of any narcotic, unless administered on the advice of a physician.

- Injury or illness sustained by voluntary use of illegal drugs or hallucinogenics.

The Company's A4800W-CO policy forms state, in part, the following:

General Exclusions and Limitations

This policy does not cover any of the following expenses or charges:

- For Illness or Injury caused by, contributed to, or resulting from your Intoxication or use of alcohol, illegal drugs, voluntary use of any controlled substance (as defined by statute), or use of legal prescription or over-the –counter drugs that are not taken in the dosage or for the purpose prescribed or recommended by your Physician. This exclusion shall apply even if no traffic or criminal charges are filed or proposed.

The Company's A3601-CO (1-97), A3603-CO (1-97), A3604-CO (1-97), A3605-CO (1-97), A3606-CO (1-97) and A2192-CO (1-99) policy forms state, in part, the following:

General Exclusions and Limitations

This policy does not cover:

- Expenses incurred for treatment of injury or illness occurring while under the influence of alcohol, illegal drugs, and/or hallucinogenics

- Injury or illness sustained by voluntary use of illegal drugs or hallucinogenics.

The Company's A3800 policy form states, in part, the following:

General Provisions

Part J.

- **Intoxicants and Narcotics:** We will not be liable for loss sustained because of a covered person being intoxicated. Nor will we be liable for loss sustained because of a covered person being under the influence of a narcotic. This does not apply to narcotics given on the advice of a physician.

Form	Form Number
Catastrophic Major Medical-PPO High Deductible	A4024
Catastrophic Major Medical-Non-PPO HSA	A4024
Catastrophic Major Medical-PPO HSA	A4024
Catastrophic Major Medical-PPO HSA with Optional Benefits	A4024
Comprehensive Major Medical-PPO High Deductible	A4024
Comprehensive Major Medical-Non-PPO HSA	A4204
Comprehensive Major Medical-PPO HSA	A4204
Comprehensive Major Medical-Non-PPO	A4204
Comprehensive Major Medical-All PPO Plans	A4204
Catastrophic Major Medical	A4800W-CO
Comprehensive Major Medical	A4800W-CO
Major Medical Policy	A3601-CO (1-97)
Major Medical Policy	A3603-CO (1-97)
Major Medical Policy	A3604-CO (1-97)
Major Medical Policy	A3605-CO (1-97)
Major Medical Policy	A3606-CO (1-97)
Short Term Major Medical Policy	A2192-CO (1-99)
Major Medical Policy	A3800

Recommendation No 1:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-201, C.R.S. In the event the Company is unable to provide such documentation, it should be required to provide evidence to the Division that it has revised all affected policy forms to provide coverage to or on behalf of an insured because the insured or a covered dependent sustained an injury while intoxicated or under the influence of a controlled substance as required by Colorado insurance law.

Issue E2: Failure, in some cases, to include or to completely include the required language related to contract changes within the Company's policy forms.

Section 10-16-202, C.R.S., Required provisions in individual sickness and accident policies, states in part:

(1) Except as provided in section 10-16-204, C.R.S., each such policy delivered or issued for delivery to any person in this state shall contain the provisions specified in this section in the words in which the same appear in this section; except that the insurer, at its option, may substitute for one or more of such provisions corresponding provisions of different wording approved by the commissioner which are in each instance not less favorable in any respect to the insured or the beneficiary. Such provisions shall be preceded individually by the caption appearing in this section or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the commissioner may approve.

(2) A provision as follows: "Entire contract--changes: This policy, *including the endorsements and the attached papers, if any*, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions." [Emphasis added.]

It appears that the Company is not in compliance with Colorado insurance law in that its policy forms either do not include the mandatory "Entire Contract-Changes" language required by § 10-16-202(2), C.R.S., or the language is incomplete in that the required reference to endorsements and attached papers, if any, is not included.

The Company's A4204 and A4800W-CO policy forms do not include the mandatory "Entire Contract-Changes" language.

The Company's A3601-CO (1-97), A3603-CO (1-97), A3604-CO (1-97), A3605-CO (1-97), A3606-CO (1-97) and A2192-CO (1-99) policy forms are incomplete in that they state, in part, the following:

Policy Provisions

This is Your Entire Contract of Insurance with Us:

- This policy constitutes the entire contract of insurance between you and us.

How Changes to this Contract can be Made:

- Any changes to this policy must be approved by one of our Officers and that approval must appear in this policy. Our agent cannot change this policy in any way or waive any of its provisions.

Form	Form Number
Catastrophic Major Medical-PPO High Deductible	A4024
Catastrophic Major Medical-Non-PPO HSA	A4024
Catastrophic Major Medical-PPO HSA	A4024
Catastrophic Major Medical-PPO HSA with Optional Benefits	A4024
Comprehensive Major Medical-PPO High Deductible	A4024
Comprehensive Major Medical-Non-PPO HSA	A4204
Comprehensive Major Medical-PPO HSA	A4204
Comprehensive Major Medical-Non-PPO	A4204
Comprehensive Major Medical-All PPO Plans	A4204
Catastrophic Major Medical	A4800W-CO
Comprehensive Major Medical	A4800W-CO
Major Medical Policy	A3601-CO (1-97)
Major Medical Policy	A3603-CO (1-97)
Major Medical Policy	A3604-CO (1-97)
Major Medical Policy	A3605-CO (1-97)
Major Medical Policy	A3606-CO (1-97)
Short Term Major Medical Policy	A2192-CO (1-99)

Recommendation No. 2:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-202, C.R.S. In the event the Company is unable to provide such documentation, it should be required to provide evidence to the Division that it has revised all affected policy forms to completely include the required language related to contract changes as required by Colorado insurance law.

Issue E3: Failure, in some cases, to include the required one year timeframe regarding time limits on certain defenses.

Section 10-16-118, C.R.S., Limitations on preexisting condition limitations, states in part:

(1) A health coverage plan that covers residents of this state:

…

(a)(II) *If it is an individual health benefit plan, or a group health coverage plan to which subparagraph (I) of this paragraph (a) does not apply, shall not deny, exclude, or limit benefits for a covered individual because of a preexisting condition for losses incurred more than twelve months following the effective date of coverage and may not define a preexisting condition more restrictively than an injury, sickness, or pregnancy for which a person incurred charges, received medical treatment, consulted a health care professional, or took prescription drugs within twelve months.* [Emphasis added.]

Section 10-16-202, C.R.S., Required provisions in individual sickness and accident policies, states in part:

(1) Except as provided in section 10-16-204, C.R.S., each such policy delivered or issued for delivery to any person in this state shall contain the provisions specified in this section in the words in which the same appear in this section; except that the insurer, at its option, may substitute for one or more of such provisions corresponding provisions of different wording approved by the commissioner which are in each instance not less favorable in any respect to the insured or the beneficiary. Such provisions shall be preceded individually by the caption appearing in this section or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the commissioner may approve.

…

(3) Provisions as follows:

…

(b) *Except for individual disability income insurance policies, no claim for loss incurred or disability, as defined in the policy, commencing after one year from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or a specific description effective on the date of loss had existed prior to the effective date of coverage of this policy.* [Emphasis added.]

It appears that the Company is not in compliance with Colorado insurance law in that its policy forms indicate a two year timeframe instead of the required one year timeframe for consideration of whether a condition may be pre-existing as stipulated by § 10-16-202(3)(b), C.R.S.

The Company's A4800W-CO policy forms state, in part, the following:

Claims Provisions

Time Limit on Certain Defenses:

- After 2 years from the issue date, no misstatements made by the applicant in the application for this policy, except fraudulent misstatements, shall be used to void the policy or to deny a claim for loss incurred or total disability commencing after the expiration of such 2 year period. *No claim for loss incurred or total disability commencing after 2 years from the issue date shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the issue date.* [Emphasis added.]

The Company's A3800 policy form states, in part, the following:

Exclusions and Limitations

Preexisting Conditions Limitations:

- We will not pay benefits for a preexisting condition unless:
    - the covered person's preexisting condition was fully disclosed to us during our underwriting process under this policy; and
    - coverage of the preexisting condition has not been excluded or limited by name or specific description.

However, this preexisting condition limitation will not apply to a loss incurred more than 2 years after the effective date of coverage of each covered person. [Emphasis added.]

Form	Form Number
Catastrophic Major Medical	A4800W-CO
Comprehensive Major Medical	A4800W-CO
Major Medical Policy	A3800

Recommendation No. 3:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-202, C.R.S. In the event the Company is unable to provide such documentation, it should be required to provide evidence to the Division that it has revised all affected policy forms to include the required one year timeframe regarding time limits on certain defenses as required by Colorado insurance law. The Company should also be required to conduct a self-audit to identify and correct any claims that may have been incorrectly denied due to this incorrect language, from January 1, 2008 to the present.

Issue E4: Failure, in some cases, to include the mandatory language related to notice of claim.

Section 10-16-202, C.R.S., Required provisions in individual sickness and accident policies, states in part:

(1) Except as provided in section 10-16-204, C.R.S., each such policy delivered or issued for delivery to any person in this state shall contain the provisions specified in this section in the words in which the same appear in this section; except that the insurer, at its option, may substitute for one or more of such provisions corresponding provisions of different wording approved by the commissioner which are in each instance not less favorable in any respect to the insured or the beneficiary. Such provisions shall be preceded individually by the caption appearing in this section or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the commissioner may approve.

…

(6)(a) Provisions as follows: "Notice of claim: Written notice of claim must be given to the insurer within twenty days after the occurrence or commencement of any loss covered by the policy or as soon thereafter as is reasonably possible. *Notice given by or on behalf of the insured or the beneficiary to the insurer at (insert the location of such office as the insurer may designate for the purpose), or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer."* [Emphasis added.]

It appears that the Company is not in compliance with Colorado insurance law in that its policy forms do not include, or do not completely include, the mandatory language required by § 10-16-202(6)(a), C.R.S.

Forms A2192-CO (1-99), A3601-CO (1-97), A3603-CO (1-97), A3604-CO (1-97), A3605-CO (1-97), and A3606-CO (1-97) do not include the mandatory "Notice of Claim" language.

The following Company's policy forms do not provide the location where the notice needs to be sent, nor do they state that notice provided to any authorized agent of the insured shall be deemed notice to the insurer.

The Company's A4204 policy forms state, in part, the following:

Claim Provisions

Notice of Loss/Claim:

- Written notice of loss or claim must be given to us within 20 days after the date of any covered loss. If notice is not given within 20 days, a claims will not be denied of reduced if notice was given as soon as reasonably possible.

The Company's A4800W policy forms state, in part, the following:

Claim Provisions

Notice of Loss/Claim:

…

- We must receive your written notice of loss or claim within 20 days after the date of any covered loss. "Loss" as used in this context means the medical expenses you incur resulting from a covered illness or injury. We do not require that the written notice be on a particular form; rather, you can simply send us a letter in which you inform us that you have incurred medical expenses under this policy. If we have not received the written notice within 20 days of the date of loss, we will not deny or reduce a claim as long as you send us the notice as soon as is reasonable possible.

Form	Form Number
Catastrophic Major Medical-PPO High Deductible	A4024
Catastrophic Major Medical-Non-PPO HSA	A4024
Catastrophic Major Medical-PPO HSA	A4024
Catastrophic Major Medical-PPO HSA with Optional Benefits	A4024
Comprehensive Major Medical-PPO High Deductible	A4024
Comprehensive Major Medical-Non-PPO HSA	A4204
Comprehensive Major Medical-PPO HSA	A4204
Comprehensive Major Medical-Non-PPO	A4204
Comprehensive Major Medical-All PPO Plans	A4204
Catastrophic Major Medical	A4800W-CO
Comprehensive Major Medical	A4800W-CO
Major Medical Policy	A3601-CO (1-97)
Major Medical Policy	A3603-CO (1-97)
Major Medical Policy	A3604-CO (1-97)
Major Medical Policy	A3605-CO (1-97)
Major Medical Policy	A3606-CO (1-97)
Short Term Major Medical Policy	A2192-CO (1-99)

Recommendation No. 4:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-202, C.R.S. In the event the Company is unable to provide such documentation, it should be required to provide evidence to the Division that it has revised all affected policy forms to include the mandatory language related to notice of claim as required by Colorado insurance law.

Issue E5:	**Failure, in some cases, to include the mandatory language related to payment of claims.**

Section 10-16-202, C.R.S., Required provisions in individual sickness and accident policies, states in part:

> (1) Except as provided in section 10-16-204, C.R.S., each such policy delivered or issued for delivery to any person in this state shall contain the provisions specified in this section in the words in which the same appear in this section; except that the insurer, at its option, may substitute for one or more of such provisions corresponding provisions of different wording approved by the commissioner which are in each instance not less favorable in any respect to the insured or the beneficiary. Such provisions shall be preceded individually by the caption appearing in this section or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the commissioner may approve.
>
> …
>
> (10)(a) A provision as follows: "Payment of claims: Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at the option of the insurer, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the insured."

It appears that the Company is not in compliance with Colorado insurance law in that its policy forms, in some cases, do not include the mandatory language regarding payment of claims required by § 10-16-202(10)(a), C.R.S.

Form	Form Number
Catastrophic Major Medical-PPO High Deductible	A4024
Catastrophic Major Medical-Non-PPO HSA	A4024
Catastrophic Major Medical-PPO HSA	A4024
Catastrophic Major Medical-PPO HSA with Optional Benefits	A4024
Comprehensive Major Medical-PPO High Deductible	A4024
Comprehensive Major Medical-Non-PPO HSA	A4204
Comprehensive Major Medical-PPO HSA	A4204
Comprehensive Major Medical-Non-PPO	A4204
Comprehensive Major Medical-All PPO Plans	A4204
Catastrophic Major Medical	A4800W-CO
Comprehensive Major Medical	A4800W-CO
Major Medical Policy	A3601-CO (1-97)
Major Medical Policy	A3603-CO (1-97)

Major Medical Policy	A3604-CO (1-97)
Major Medical Policy	A3605-CO (1-97)
Major Medical Policy	A3606-CO (1-97)
Short Term Major Medical Policy	A2192-CO (1-99)

<u>Recommendation No. 5:</u>

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-202, C.R.S. In the event the Company is unable to provide such documentation, it should be required to provide evidence to the Division that it has revised all affected policy forms to include the mandatory language related to payment of claims as required by Colorado insurance law.

Issue E6:	**Failure, in some cases, to include the mandatory language related to change of beneficiary.**

Section 10-16-202, C.R.S., Required provisions in individual sickness and accident policies, states in part:

(1) Except as provided in section 10-16-204, C.R.S., each such policy delivered or issued for delivery to any person in this state shall contain the provisions specified in this section in the words in which the same appear in this section; except that the insurer, at its option, may substitute for one or more of such provisions corresponding provisions of different wording approved by the commissioner which are in each instance not less favorable in any respect to the insured or the beneficiary. Such provisions shall be preceded individually by the caption appearing in this section or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the commissioner may approve.

…

(13)(a) *A provision as follows: "Change of beneficiary: Unless the insured makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy or to any change of beneficiary or beneficiaries, or to any other changes in this policy."* [Emphasis added.]

It appears that the Company is not in compliance with Colorado insurance law in that its policy forms do not include the mandatory language regarding change of beneficiary required by § 10-16-202(13)(a), C.R.S.

<u>Form</u>	<u>Form Number</u>
Catastrophic Major Medical-PPO High Deductible	A4024
Catastrophic Major Medical-Non-PPO HSA	A4024
Catastrophic Major Medical-PPO HSA	A4024
Catastrophic Major Medical-PPO HSA with Optional Benefits	A4024
Comprehensive Major Medical-PPO High Deductible	A4024
Comprehensive Major Medical-Non-PPO HSA	A4204
Comprehensive Major Medical-PPO HSA	A4204
Comprehensive Major Medical-Non-PPO	A4204
Comprehensive Major Medical-All PPO Plans	A4204
Catastrophic Major Medical	A4800W-CO
Comprehensive Major Medical	A4800W-CO
Major Medical Policy	A3601-CO (1-97)
Major Medical Policy	A3603-CO (1-97)
Major Medical Policy	A3604-CO (1-97)
Major Medical Policy	A3605-CO (1-97)
Major Medical Policy	A3606-CO (1-97)
Short Term Major Medical Policy	A2192-CO (1-99)

Recommendation No. 6:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-202. In the event the Company is unable to provide such documentation, it should be required to provide evidence to the Division that it has revised all affected policy forms to include the mandatory language related to change of beneficiary as required by Colorado insurance law.

Issue E7:	**Failure, in some cases, to include the mandatory language related to early intervention services.**

Section 10-16-104, C.R.S., Mandatory coverage provisions-definitions, states in part:

(1.3) Early intervention services.

(b)(I) *All individual and group sickness and accident insurance policies issued by an entity subject to part 2 of this article on or after January 1, 2008,* and all service or indemnity contracts issued by an entity subject to part 3 or 4 of this article on or after January 1, 2008, *that include dependent coverage shall provide coverage for early intervention services delivered by a qualified early intervention service provider to an eligible child. Early intervention services specified in an eligible child's IFSP shall qualify as meeting the standard for medically necessary health care services as used by private health insurance plans.* [Emphasis added.]

It appears that the Company is not in compliance with Colorado insurance law in that its policy forms, in some cases, do not include the mandatory early intervention services provision required by § 10-16-104(1.3)(b)(I), C.R.S.

Form	Form Number
Catastrophic Major Medical-PPO High Deductible	A4024
Catastrophic Major Medical-Non-PPO HSA	A4024
Catastrophic Major Medical-PPO HSA	A4024
Catastrophic Major Medical-PPO HSA with Optional Benefits	A4024
Comprehensive Major Medical-PPO High Deductible	A4024
Comprehensive Major Medical-Non-PPO HSA	A4204
Comprehensive Major Medical-PPO HSA	A4204
Comprehensive Major Medical-Non-PPO	A4204
Comprehensive Major Medical-All PPO Plans	A4204
Major Medical Policy	A3601-CO (1-97)
Major Medical Policy	A3603-CO (1-97)
Major Medical Policy	A3604-CO (1-97)
Major Medical Policy	A3605-CO (1-97)
Major Medical Policy	A3606-CO (1-97)
Major Medical Policy	A3800

Recommendation No. 7:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-104, C.R.S. In the event the Company is unable to provide such documentation, it should be required to provide evidence to the Division that it has revised all affected policy forms to include the mandatory language related to early intervention services as required by Colorado insurance law. The Company should also be required to conduct a self-audit to identify and correct any claims that may have been incorrectly denied due to this incorrect language, from January 1, 2008 to the present.

Issue E8: Failure, in some cases, to provide complete benefits related to therapies for congenital defects and birth abnormalities.

Section 10-16-104, C.R.S., Mandatory coverage provisions-definitions, states in part:

(1.7) Therapies for congenital defects and birth abnormalities.

(a) After the first thirty-one days of life, policy limitations and exclusions that are generally applicable under the policy may apply; except that all individual and group health benefit plans shall provide medically necessary physical, occupational, and speech therapy for the care and treatment of congenital defects and birth abnormalities for a covered child *from the child's third birthday to the child's sixth birthday.* [Emphasis added.]

It appears that the Company is not in compliance with Colorado insurance law in that its policy forms either do not include the mandatory coverage provision to provide coverage for physical, occupational, and speech therapy for the care and treatment of congenital defects and birth abnormalities for a covered child from the child's third birthday to the child's sixth birthday, or the policy forms only provide coverage to age five instead of age six.

The Company's A3800, A3601-CO (1-97), A3603-CO (1-97), and A3604-CO (1-97) policy forms do not include the mandatory language concerning therapies for congenital defects and birth abnormalities.

The Company's A4024, A3605-CO (1-97), and A3606-CO (1-97) policy forms state, in part (with minor variances), the following:

Covered Expenses:

- Medically necessary care and treatment of medically diagnosed congenital defects and birth abnormalities for the first 31 days of a newborn's life, notwithstanding policy limitations and exclusions applicable to other conditions or procedures covered by this policy. After the first 31 days of life, policy limitations and exclusions that are generally applicable under this policy apply. Such care and treatment includes:
    - Medically necessary physical, occupational and speech therapy for the care and treatment of congenital defects and birth abnormalities for covered children *up to five years of age*. [Emphasis added.]

Form	Form Number
Catastrophic Major Medical-PPO High Deductible	A4024
Catastrophic Major Medical-Non-PPO HSA	A4024
Catastrophic Major Medical-PPO HSA	A4024
Catastrophic Major Medical-PPO HSA with Optional Benefits	A4024
Comprehensive Major Medical-PPO High Deductible	A4024
Comprehensive Major Medical-Non-PPO HSA	A4204

Comprehensive Major Medical-PPO HSA	A4204
Comprehensive Major Medical-Non-PPO	A4204
Comprehensive Major Medical-All PPO Plans	A4204
Major Medical Policy	A3601-CO (1-97)
Major Medical Policy	A3603-CO (1-97)
Major Medical Policy	A3604-CO (1-97)
Major Medical Policy	A3605-CO (1-97)
Major Medical Policy	A3606-CO (1-97)
Major Medical Policy	A3800

Recommendation No. 8:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-104, C.R.S. In the event the Company is unable to provide such documentation, it should be required to provide evidence to the Division that it has revised all affected policy forms to provide complete benefits related to therapies for congenital defects and birth abnormalities as required by Colorado insurance law. The Company should also be required to conduct a self-audit to identify and correct any claims that may have been incorrectly denied due to this incorrect language, from January 1, 2008 to the present.

Issue E9: Failure, in some cases, to provide coverage to stepchildren that do not permanently reside with an insured.

Section 10-16-104, C.R.S., Mandatory coverage provisions - definitions, states in part:

(6) Dependent children.

(a) No entity subject to the provisions of this article or section 607 (1) of the federal "Employee Retirement Income Security Act of 1974", as amended, shall refuse to accept and honor an otherwise valid claim for a covered benefit that is filed by either parent of a covered child, or by the state department of social services in the case of an assignment under section 26-13-106, C.R.S., who submits valid copies of medical bills. A claim submitted by a custodial parent who is not the insured under a policy issued by an entity subject to the provisions of this article or section 607 (1) of the federal "Employee Retirement Income Security Act of 1974", as amended, shall be deemed a valid assignment of benefits for payment to the health care provider.

(b) *No entity described in paragraph (a) of this subsection (6) shall refuse to provide coverage for a dependent child under the health plan of the child's parent for the sole reason that the child:*

(I) *Does not live in the home of the parent applying for the policy* [Emphases added.]

It appears that the Company is not in compliance with Colorado insurance law in that its policy forms, in some cases, require stepchildren to permanently reside with the insured in order to be eligible for coverage.

The Company's A4024 policy forms state, in part, the following:

Definitions:

- Dependent:
  - Your unmarried child(ren) until the date the child attains age 19, including:
    - a stepchild *who permanently resides with you.* [Emphasis added.]

The Company's A4800W-CO policy forms state, in part, the following:

Definitions:

- Dependent: A Dependent can be any of the following:
  - Your unmarried child under age 19, including:
    - A stepchild *who permanently resides with you,* [Emphasis added.]

The Company's A3601-CO (1-97), A3603-CO (1-97), A3604-CO (1-97), A3605-CO (1-97), A3606-CO (1-97) and A2192-CO (1-99) policy forms state, in part, the following:

Definitions:

- Covered Dependents:
  - Covered dependents include:
    - Your stepchild(ren), *provided the child(ren) residing with you* and are dependent upon you for a majority of financial support; [Emphasis added.]

Form	Form Number
Catastrophic Major Medical-PPO High Deductible	A4024
Catastrophic Major Medical-Non-PPO HSA	A4024
Catastrophic Major Medical-PPO HSA	A4024
Catastrophic Major Medical-PPO HSA with Optional Benefits	A4024
Comprehensive Major Medical-PPO High Deductible	A4024
Comprehensive Major Medical-Non-PPO HSA	A4204
Comprehensive Major Medical-PPO HSA	A4204
Comprehensive Major Medical-Non-PPO	A4204
Comprehensive Major Medical-All PPO Plans	A4204
Catastrophic Major Medical	A4800W-CO
Comprehensive Major Medical	A4800W-CO
Major Medical Policy	A3601-CO (1-97)
Major Medical Policy	A3603-CO (1-97)
Major Medical Policy	A3604-CO (1-97)
Major Medical Policy	A3605-CO (1-97)
Major Medical Policy	A3606-CO (1-97)
Short Term Major Medical Policy	A2192-CO (1-99)

Recommendation No. 9:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-104, C.R.S. In the event the Company is unable to provide such documentation, it should be required to provide evidence to the Division that it has revised all affected policy forms to provide coverage to stepchildren that do not permanently reside with an insured as required by Colorado insurance law.

Issue E10: Failure, in some cases, to include the mandatory coverage provision, or to provide the required number of number of well-child visits, related to child health supervision services.

Section 10-16-104, C.R.S., Mandatory coverage provisions-definitions, states in part:

(11) Child health supervision services.

(a) For purposes of this subsection (11), unless the context otherwise requires, *"child health supervision services" means those preventive services and immunizations required to be provided in basic and standard health benefit plans pursuant to section 10-16-105 (7.2), to dependent children up to age thirteen.* Such services shall be provided by a physician or pursuant to a physician's supervision or by a primary health care provider who is a physician's assistant or registered nurse who has additional training in child health assessment and who is working in collaboration with a physician. [Emphasis added.]

(b) *An individual, small group, or large group health benefit plan issued in Colorado or covering a Colorado resident that provides coverage for a family member of the insured or subscriber, shall, as to such family member's coverage, also provide that the health insurance benefits applicable to children include coverage for child health supervision services up to the age of thirteen. Each such plan shall, at a minimum, provide benefits for preventive child health supervision services.* A plan described in this paragraph (b) may provide that child health supervision services rendered during a periodic review shall only be covered to the extent such services are provided during the course of one visit by or under the supervision of a single physician, physician's assistant, or registered nurse. [Emphasis added.]

Colorado Insurance Regulation 4-6-5, Concerning Small Employer Group Health Benefit Plans and the Basic and Standard Health Benefit Plans, states in part:

Attachment 1

Covered Preventive Services

Age 0-12 months	1 newborn home visit during first week of life if newborn released from hospital less than 48 hours after delivery.
	6 well-child visits [Emphasis added.]
	1 PKU
Age 13-35 months	*3 well-child visits* [Emphasis added.]
Age 3-6	*4 well-child visits* [Emphasis added.]
Age 7-12	*4 well-child visits* [Emphasis added.]

It appears that the Company is not in compliance with Colorado insurance law in that its policy forms do not meet the mandatory coverage provision required by paragraphs (a) and (b) of § 10-16-104(11), C.R.S, and Colorado Insurance Regulation 4-6-5. Specifically, the Company's policy forms either do not include the required provisions, or the number of child health supervision visits noted in the policy forms do not meet the required number of well-child visits mandated by Colorado insurance law.

The Company's A3800 policy forms do not include the required child health supervision services provision.

The Company's A4024 policy forms state, in part, the following:

Medical Expense Benefit

Covered Expenses:

- Child health supervision services. Such services shall include the following:
  - One newborn home visit during the first week of life if the newborn is released from the hospital less than 48 hours after delivery.
  - *Five child health supervision visits and one PKU visit from birth through 12 months;*
  - *Two child health supervision visits from 13 months through 35 months;*
  - *Three child health supervision visits from three years to three years through six years of age* (SIC)*;*
  - *Three child health supervision visits from six years to three years through 13 years of age* (SIC) [Emphases added.]*;* and
  - Immunizations, as defined in Colorado Insurance Regulation 4-6-5 – Attachment 1, or as such regulation is amended.

The Company's A3601-CO (1-97), A3603-CO (1-97), A3604-CO (1-97), A3605-CO (1-97), A3606-CO (1-97) and A2192-CO (1-99) policy forms state, in part, the following:

Covered Expenses

Other Covered Charges Include:

- child health supervision services. Pediatric preventive services and immunizations for a covered dependent from birth to age 13, as defined by Standards of Child Health Care issued by the American Academy of Pediatrics. This policy will cover up to *5 child health supervision visits and one PKU from birth through 12 months, 2 child health supervision visits from 13 months through 35 months, and 3 child health supervision visits from 3 years through 12 years.* This covered expense is not subject to the deductible. [Emphasis added.]

The Company's R4800W-CO policy form states, in part, the following:

- Child Health Supervision Services up to the Age of 13 as follows:
  - One newborn visit during the first week of life if the newborn is released from the Hospital less than 48 hours after delivery;
  - One test or screening for Phenylketonuria (PKU) from birth to 12 months of Age;
  - *Five Well-Child Visits from birth to 12 months of Age;*
  - *Two Well-Child Visits from 13 to 35 months of Age;*
  - *Three Well-Child Visits from 3 to 6 years of Age; and*
  - *Three Well-Child Visits from 7 to 13 years of Age.* [Emphases added.]

Form	Form Number
Catastrophic Major Medical-PPO High Deductible	A4024
Catastrophic Major Medical-Non-PPO HSA	A4024
Catastrophic Major Medical-PPO HSA	A4024
Catastrophic Major Medical-PPO HSA with Optional Benefits	A4024
Comprehensive Major Medical-PPO High Deductible	A4024
Comprehensive Major Medical-Non-PPO HSA	A4204
Comprehensive Major Medical-PPO HSA	A4204
Comprehensive Major Medical-Non-PPO	A4204
Comprehensive Major Medical-All PPO Plans	A4204
State Mandated Benefits Rider	R4800W-CO
Major Medical Policy	A3601-CO (1-97)
Major Medical Policy	A3603-CO (1-97)
Major Medical Policy	A3604-CO (1-97)
Major Medical Policy	A3605-CO (1-97)
Major Medical Policy	A3606-CO (1-97)
Major Medical Policy	A3800
Short Term Major Medical Policy	A2192-CO (1-99)

Recommendation No. 10:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-104, C.R.S. and Colorado Insurance Regulation 4-6-5. In the event the Company is unable to provide such documentation, it should be required to provide evidence to the Division that it has revised all affected policy forms to include the mandatory coverage provision related to child health supervision services as required by Colorado insurance law. The Company should also be required to conduct a self-audit to identify and correct any claims that may have been incorrectly denied due to this incorrect language, from January 1, 2008 to the present.

Issue E11: Failure, in some instances, to include the mandatory coverage for prosthetic devices. *This appears to be a repeat issue that was identified as issue E8 during the last market conduct exam of this Company, which was completed on June 11, 2004 covering the period of January 1, 2003 to December 31, 2003.*

Section 10-16-104, C.R.S., Mandatory coverage provisions-definitions, states in part:

(14) Prosthetic devices.

(a) Any health benefit plan, except supplemental policies covering a specified disease or other limited benefit, that provides hospital, surgical, or medical expense insurance shall provide coverage for benefits for prosthetic devices that equal those benefits provided for under federal laws for health insurance for the aged and disabled pursuant to 42 U.S.C. secs. 1395k, 1395l, and 1395m and 42 CFR 414.202, 414.210, 414.228, and 410.100, as applicable to this subsection (14).

It appears that the Company is not in compliance with Colorado insurance law in that its policy forms, in some instances, do not include the mandatory coverage for prosthetic devices as required by § 10-16-104(14)(a), C.R.S.

Form	Form Number
Short Term Major Medical Policy	A2192-CO (1-99)

Recommendation No. 11:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-104, C.R.S. In the event the Company is unable to provide such documentation, it should be required to provide evidence to the Division that it has revised all affected policy forms to include the mandatory coverage for prosthetic devices as required by Colorado insurance law. The Company should also be required to conduct a self-audit to identify and correct any claims that may have been incorrectly denied due to this incorrect language, from January 1, 2008 to the present.

Issue E12: Failure, in some cases, to include the mandatory coverage for cervical cancer vaccines.

Section 10-16-104, C.R.S., Mandatory coverage provisions - definitions, states in part:

(17) Cervical cancer vaccines.

(a) All individual and all group sickness and accident insurance policies, except supplemental policies covering a specified disease or other limited benefit, that are delivered or issued for delivery within the state by an entity subject to the provisions of part 2 of this article and all individual and group health care service or indemnity contracts issued by an entity subject to the provisions of part 3 or 4 of this article, as well as any other group health care coverage offered to residents of this state, shall provide coverage for the full cost of cervical cancer vaccination for all females for whom a vaccination is recommended by the advisory committee on immunization practices of the United States department of health and human services.

It appears that the Company is not in compliance with Colorado insurance law in that its policy forms, in some cases, do not include the mandatory coverage for cervical cancer vaccines required by § 10-16-104(17)(a), C.R.S.

Form	Form Number
Catastrophic Major Medical-PPO High Deductible	A4024
Catastrophic Major Medical-Non-PPO HSA	A4024
Catastrophic Major Medical-PPO HSA	A4024
Catastrophic Major Medical-PPO HSA with Optional Benefits	A4024
Comprehensive Major Medical-PPO High Deductible	A4024
Comprehensive Major Medical-Non-PPO HSA	A4204
Comprehensive Major Medical-PPO HSA	A4204
Comprehensive Major Medical-Non-PPO	A4204
Comprehensive Major Medical-All PPO Plans	A4204
Major Medical Policy	A3601-CO (1-97)
Major Medical Policy	A3603-CO (1-97)
Major Medical Policy	A3604-CO (1-97)
Major Medical Policy	A3605-CO (1-97)
Major Medical Policy	A3606-CO (1-97)
Major Medical Policy	A3800

Recommendation No. 12:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-104, C.R.S. In the event the Company is unable to provide such documentation, it should be required to provide evidence to the Division that it has revised all affected policy forms to include the mandatory coverage for cervical cancer vaccines as required by Colorado insurance law. The Company should also be required to conduct a self-audit to identify and correct any claims that may have been incorrectly denied due to this incorrect language, from January 1, 2008 to the present.

Issue E13: Failure to offer coverage for dependents up to age twenty-five.

Section 10-16-104.3, C.R.S., Dependent health coverage for persons under twenty-five years of age, states in part:

> (1) *All individual* and group *sickness and accident insurance policies providing coverage within the state by an entity subject to the provisions of part 2 of this article* and all group health service contracts issued by an entity subject to the provisions of part 3 or 4 of this article *that offer dependent coverage shall offer to the parent,* for an additional premium if applicable, by rider or supplemental policy provision, *the same dependent coverage for an unmarried child who is under twenty-five years of age, and is not a dependent as defined by section 10-16-102 if such child:*
>
> (a) *Has the same legal residence as the parent; or*
>
> (b) *Is financially dependent upon the parent.* [Emphases added.]

It appears that the Company is not in compliance with Colorado insurance law in that its policy forms do not include the mandatory offer of coverage for dependents up to age twenty-five (25). Although the policy forms do provide coverage for dependents over age nineteen (19), who are full-time students or who are disabled, there is no offer of coverage in the policy forms (or the application) for dependents age nineteen (19) to twenty-five (25) who have the same legal residence as the insured or are financially dependent on the insured as required by § 10-16-104.3(1), C.R.S.

Form	Form Number
Catastrophic Major Medical-PPO High Deductible	A4024
Catastrophic Major Medical-Non-PPO HSA	A4024
Catastrophic Major Medical-PPO HSA	A4024
Catastrophic Major Medical-PPO HSA with Optional Benefits	A4024
Comprehensive Major Medical-PPO High Deductible	A4024
Comprehensive Major Medical-Non-PPO HSA	A4204
Comprehensive Major Medical-PPO HSA	A4204
Comprehensive Major Medical-Non-PPO	A4204
Comprehensive Major Medical-All PPO Plans	A4204
Catastrophic Major Medical	A4800W-CO
Comprehensive Major Medical	A4800W-CO
Major Medical Policy	A3601-CO (1-97)
Major Medical Policy	A3603-CO (1-97)
Major Medical Policy	A3604-CO (1-97)
Major Medical Policy	A3605-CO (1-97)
Major Medical Policy	A3606-CO (1-97)
Major Medical Policy	A3800
Short Term Major Medical Policy	A2192-CO (1-99)

Recommendation No. 13:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-104.3, C.R.S. In the event the Company is unable to provide such documentation, it should be required to provide evidence to the Division that it has revised all affected policy forms to include the mandatory offer of coverage for dependents not already eligible, up to age twenty-five as required by Colorado insurance law.

Issue E14: Failure to include the required disclosure regarding coverage for treatment of intractable pain.

Section 10-16-107, C.R.S., Rate regulation – rules – approval of policy forms – benefit certificates – evidences of coverage – benefits ratio – disclosures on treatment of intractable pain, states in part:

> (7)(a) *A service or indemnity contract issued or renewed on or after January 1, 1998, by any entity subject to part 2,* 3, or 4 *of this article shall disclose in the contract and in information on coverage presented to consumers whether the health coverage plan or managed care plan provides coverage for treatment of intractable pain.* If the contract is silent on coverage of intractable pain, then the contract shall be presumed to offer coverage for the treatment of intractable pain. If the contract is silent or if the plan specifically includes coverage for the treatment of intractable pain, the plan shall provide access to such treatment for any individual covered by the plan. [Emphasis added.]

It appears that the Company is not in compliance with Colorado insurance law in that its policy forms do not include the required disclosure regarding coverage for treatment of intractable pain.

Form	Form Number
Catastrophic Major Medical-PPO High Deductible	A4024
Catastrophic Major Medical-Non-PPO HSA	A4024
Catastrophic Major Medical-PPO HSA	A4024
Catastrophic Major Medical-PPO HSA with Optional Benefits	A4024
Comprehensive Major Medical-PPO High Deductible	A4024
Comprehensive Major Medical-Non-PPO HSA	A4204
Comprehensive Major Medical-PPO HSA	A4204
Comprehensive Major Medical-Non-PPO	A4204
Comprehensive Major Medical-All PPO Plans	A4204
Catastrophic Major Medical	A4800W-CO
Comprehensive Major Medical	A4800W-CO
Major Medical Policy	A3601-CO (1-97)
Major Medical Policy	A3603-CO (1-97)
Major Medical Policy	A3604-CO (1-97)
Major Medical Policy	A3605-CO (1-97)
Major Medical Policy	A3606-CO (1-97)
Major Medical Policy	A3800
Short Term Major Medical Policy	A2192-CO (1-99)

Recommendation No. 14:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-107, C.R.S. In the event the Company is unable to provide such documentation, it should be required to provide evidence to the Division that it has revised all affected policy forms to include the required disclosure regarding coverage for treatment of intractable pain required by Colorado insurance law. The Company should also be required to conduct a self-audit to identify and correct any claims that may have been incorrectly denied due to this incorrect language, from January 1, 2008 to the present.

Issue E15:	**Failure, in some cases, to include the appropriate definition of "Dependent" within the Company's policy forms.**

Section 10-16-102, C.R.S., Definitions, states in part:

> (14) "Dependent" means a spouse, an unmarried child under nineteen years of age, an unmarried child who is a full-time student under twenty-four years of age and who is financially dependent upon the parent, and an unmarried child of any age who is medically certified as disabled and dependent upon the parent.

It appears that the Company is not in compliance with Colorado insurance law in that its policy forms, in some cases, define "Dependent" more restrictively than the definition included in Colorado insurance law. Specifically:

- The policy forms either do not specifically include a spouse within their definition of dependent, or they require that a covered spouse must be under the age of sixty-five (65).

- The language defining disabled dependents requires that the dependent be incapable of self-sustaining employment, be fully dependent on the policyholder for financial support or lifetime care, have a disability that came into existence prior to age nineteen (19), and/or be insured on the date immediately preceding the day the insurance would have terminated due to age.

- The policy forms, in some cases, require that a dependent must be fully dependent on the policyholder for financial support.

The Company's A4024 policy forms state, in part, the following:

Definitions:

- Dependent:
  - Your spouse *under the age of 65* (if not legally separated from you). [Emphasis added.]
  - The term dependent will also include your unmarried child who is:
    - *Incapable of self-sustaining employment by reason of disability* (including mental retardation, mental illness or disorder, or physical handicap). We must be furnished proof of incapacity. We may require proof of continued incapacity each year after the first two-year period that insurance has been extended; [Emphasis added.]
    - *Fully dependent on you for financial support;* [Emphasis added.]
    - *Insured on the date immediately preceding the day the insurance would have terminated due to age;* [Emphasis added.]

The Company's A4800W-CO policy forms state, in part, the following:

Definitions:

- Dependent: A Dependent can be any of the following:
    - Your spouse *under the age of 65* if said spouse is not legally separated from you;
    - The term dependent also will include your unmarried child age 19 or older who is:
        - *Incapable of self-sustaining employment because of the child's disability* (including mental retardation, mental illness or disorder, or physical handicap). In order to be considered in this category, you must furnish proof of the child's incapacity within 31 days of the date insurance would have otherwise terminated due to age. We may require proof of continued incapacity each year after the first two-year period that insurance has been extended;
        - *Fully dependent on you or other care Providers for lifetime care and supervision.* "Other care Providers" means a community-integrated living arrangement, group home, supervised apartment, or other residential service licensed or certified by the Department of Human Services, the Department of Health, or the Department of Public Aide; and;
        - *Insured on the date immediately preceding the day the insurance would have terminated due to age.* [Emphases added.]

The Company's A3601-CO (1-97), A3603-CO (1-97), A3604-CO (1-97), A3605-CO (1-97), A3606-CO (1-97) and A2192-CO (1-99) policy forms state, in part, the following:

Definitions:

- Covered Dependents:
    - Covered dependents include:
        - Your natural or legally adopted child(ren);
        - Child(ren) for whom you or your covered spouse is the legal guardian, *provided the child(ren) are dependent upon you for a majority of financial support*;
        - Your stepchild(ren), provided the child(ren) residing with you *and are dependent upon you for a majority of financial support*; [Emphases added.]
        - Child(ren) for whom there is a court order requiring you to provide medical insurance and/or pay medical expenses;
        - Your or your covered spouse's newborn child(ren) are covered, provided you send us the required premium.

- Disabled Dependent:
    - A covered dependent who is all of the following:
        - *Incapable of self-sustaining employment by reason of disability (including mental retardation, mental illness or disorder, and/or physical handicap other than pregnancy) which came into existence prior to age 19* (or 25 in the case of a full-time student);
        - Beyond the age coverage would otherwise terminate;
        - Unmarried; and
        - *Dependent upon you for the majority of his or her financial support.* [Emphases added.]

Form	Form Number
Catastrophic Major Medical-PPO High Deductible	A4024
Catastrophic Major Medical-Non-PPO HSA	A4024
Catastrophic Major Medical-PPO HSA	A4024
Catastrophic Major Medical-PPO HSA with Optional Benefits	A4024
Comprehensive Major Medical-PPO High Deductible	A4024
Comprehensive Major Medical-Non-PPO HSA	A4204
Comprehensive Major Medical-PPO HSA	A4204
Comprehensive Major Medical-Non-PPO	A4204
Comprehensive Major Medical-All PPO Plans	A4204
Catastrophic Major Medical	A4800W-CO
Comprehensive Major Medical	A4800W-CO
Major Medical Policy	A3601-CO (1-97)
Major Medical Policy	A3603-CO (1-97)
Major Medical Policy	A3604-CO (1-97)
Major Medical Policy	A3605-CO (1-97)
Major Medical Policy	A3606-CO (1-97)
Short Term Major Medical Policy	A2192-CO (1-99)

Recommendation No. 15:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-102, C.R.S. In the event the Company is unable to provide such documentation, it should be required to provide evidence to the Division that it has revised all affected policy forms to include the appropriate definition of “Dependent” as required by Colorado insurance law.

Issue E16:	**Failure, in some cases, to provide coverage for services and/or supplies furnished by a member of a covered person's immediate family, employer, business partner, or a person who ordinarily resides in the covered person's home.** *This appears to be a repeat issue that was identified as issue E7 during the last market conduct exam of this Company, which was completed on June 11, 2004 covering the period of January 1, 2003 to December 31, 2003.*

Section 10-16-104, C.R.S., Mandatory coverage provisions-definitions, states in part:

(7) Reimbursement of providers.

(a) Sickness and accident insurance.

(I)(A) Notwithstanding any provisions of any policy of sickness and accident insurance issued by an entity subject to the provisions of part 2 of this article or a prepaid dental care plan subject to the provisions of part 5 of this article, *whenever any such policy or plan provides for reimbursement for any service that may be lawfully performed by a person licensed in this state for the practice of osteopathy, medicine, dentistry, dental hygiene, optometry, psychology, chiropractic, or podiatry, reimbursement under such policy or plan shall not be denied when such service is rendered by a person so licensed.* Nothing in this part 1 or parts 2 or 5 of this article shall preclude an insurance company from setting different fee schedules in an insurance policy for different services performed by different professions, but the same fee schedule shall be used for those portions of health services that are substantially identical although performed by different professions. [Emphasis added.]

It appears that the Company is not in compliance with Colorado insurance law in that its policy forms, in some cases, exclude services and/or supplies furnished by a member of a covered person's immediate family, employer, business partner, or a person who ordinarily resides in the covered person's home. Although a carrier may exclude coverage for services and/or supplies for which a covered person would not be liable in the absence of insurance, it may not exclude coverage solely on the basis that the services and/or supplies were provided by a member of the covered person's immediate family, employer, business partner, or a person who ordinarily resides in the covered person's home.

The Company's A4800W-CO policy forms state, in part, the following:

General Exclusions and Limitations

This policy does not cover any of the following expenses or charges:

- For Treatment, services and/or supplies provided by any of the following:
  - A person who ordinarily resides in your home;
  - A member of your Immediate Family; or
  - Your employer or business partner.

The Company's A4204, A3601-CO (1-97), A3603-CO (1-97), A3604-CO (1-97), A3605-CO (1-97), A3606-CO (1-97), and A2192-CO (1-99) policy forms state, in part (with minor variances), the following:

General Exclusions and Limitations

This policy does not cover:

- Services and/or supplies furnished and/or provided by a member of a covered person's immediate family.

Form	Form Number
Catastrophic Major Medical-PPO High Deductible	A4024
Catastrophic Major Medical-Non-PPO HSA	A4024
Catastrophic Major Medical-PPO HSA	A4024
Catastrophic Major Medical-PPO HSA with Optional Benefits	A4024
Comprehensive Major Medical-PPO High Deductible	A4024
Comprehensive Major Medical-Non-PPO HSA	A4204
Comprehensive Major Medical-PPO HSA	A4204
Comprehensive Major Medical-Non-PPO	A4204
Comprehensive Major Medical-All PPO Plans	A4204
Catastrophic Major Medical	A4800W-CO
Comprehensive Major Medical	A4800W-CO
Major Medical Policy	A3601-CO (1-97)
Major Medical Policy	A3603-CO (1-97)
Major Medical Policy	A3604-CO (1-97)
Major Medical Policy	A3605-CO (1-97)
Major Medical Policy	A3606-CO (1-97)
Short Term Major Medical Policy	A2192-CO (1-99)

Recommendation No. 16:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-104, C.R.S. In the event the Company is unable to provide such documentation, it should be required to provide evidence to the Division that it has revised all affected policy forms to provide coverage for services and/or supplies furnished by a member of a covered person's immediate family, employer, business partner, or a person who ordinarily resides in the covered person's home as required by Colorado insurance law. The Company should also be required to conduct a self-audit to identify and correct any claims that may have been incorrectly denied due to this incorrect language, from January 1, 2008 to the present.

Issue E17: Failure, in some cases, to include the appropriate definition of "preexisting condition" in the Company's forms.

Section 10-16-118, C.R.S., Limitations on preexisting condition limitations, states in part:

(1) A health coverage plan that covers residents of this state:

(a)(II) *If it is an individual health benefit plan*, or a group health coverage plan to which subparagraph (I) of this paragraph (a) does not apply, *shall not deny, exclude, or limit benefits for a covered individual because of a preexisting condition for losses incurred more than twelve months following the effective date of coverage and may not define a preexisting condition more restrictively than an injury, sickness, or pregnancy for which a person incurred charges, received medical treatment, consulted a health care professional, or took prescription drugs within twelve months*. [Emphasis added.]

It appears that the Company is not in compliance with Colorado insurance law in that its policy forms, in some cases, define "preexisting condition" more restrictively than the definition included in Colorado insurance law by including conditions for which the covered person sought medical advice or treatment within the five (5) years immediately preceding the effective date of coverage , and also conditions which began prior to the effective date of coverage and manifested symptoms that would cause an ordinarily prudent person to seek diagnosis or treatment within the 5 years immediately preceding the effective date of coverage.

Colorado law does not allow carriers to define a condition as preexisting unless the treatment was received within twelve (12) months or less, and the determination must be based on actual treatment or consultation, and cannot be based solely on symptoms that would cause an ordinarily prudent person to seek diagnosis or treatment.

The Company's A3800 policy form states, in part, the following:

Exclusions and Limitations

Part E.

- **Preexisting Conditions Limitations:** We will not pay benefits for a preexisting condition unless:
  - The covered person's preexisting condition was fully disclosed to us during our underwriting process under this policy; and
  - Coverage of the preexisting condition has not been excluded or limited by name or specific description.
- *However, this preexisting conditions limitation will not apply to a loss incurred more than 2 years after the effective date of coverage of each covered person.* [Emphasis added.]

- A "preexisting condition" means an injury or sickness:
  - For which the covered person sought medical advice or treatment *within the 5 years immediately preceding the effective date of coverage*; [Emphasis added.] or
  - Which, in the opinion of a physician;
    - *began prior to the effective date of coverage and*
    - *manifested symptoms that would cause an ordinarily prudent person to seek diagnosis or treatment within the 5 years immediately preceding the effective date of coverage.* [Emphasis added.]

Form	Form Number
Major Medical Policy	A3800

Recommendation No. 17:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-118, C.R.S. In the event the Company is unable to provide such documentation, it should be required to provide evidence to the Division that it has revised all affected policy forms currently in effect to include the appropriate definition of "preexisting condition" as required by Colorado insurance law. The Company should also be required to conduct a self-audit to identify and correct any claims that may have been incorrectly denied due to this incorrect language, from January 1, 2008 to the present.

Issue E18: Failure, in some cases, to provide coverage for self-inflicted injuries, suicide, and attempted suicide to members that are insane. *This appears to be a repeat issue that was identified as issue E5 during the last market conduct exam of this Company, which was completed on June 11, 2004 covering the period of January 1, 2003 to December 31, 2003.*

Section 10-16-102, C.R.S., Definitions, states in part:

(30) "Policy of sickness and accident insurance" means any policy or contract of insurance against loss or expense resulting from the sickness of the insured, or from *the bodily injury or death of the insured by accident*, or both. [Emphasis added.]

Colorado Insurance Bulletin B-4.5, concerning Suicide Exclusions and Exclusions for Intentionally Self-Inflicted Injuries in Health Coverage Policies, states in part:

(II) Applicability and Scope

This bulletin is intended for all health carriers that use exclusions for intentionally self-inflicted injuries, including suicide and suicide attempts in their policies.

(III) Division Position

The Division adheres to the opinion of the Colorado courts that suicide, attempted suicide or other acts of self-destruction *committed while insane* are an accident. Those performing the above acts *while insane* are incapable of formulating the intent necessary to categorize the act as intentional. Therefore, health coverage policies that provide coverage for sickness, accidents and illness, either as may be required by law (such as for mental illness) or otherwise, *may not deny coverage for intentional acts committed while insane.* Such exclusions are contrary to law and are void as against public policy. Accordingly, carriers are advised to amend policy language and interpret existing policy language accordingly. [Emphasis added.]

It appears that the Company is not in compliance with Colorado insurance law in that its policy forms, in some cases, are overly restrictive with their exclusions related to self-inflicted injuries, suicide, and attempted suicide for covered members that are insane. The policy forms either do not specify that coverage for self-inflicted injuries, suicide, and attempted suicide are covered for members that are insane, or the coverage is specifically excluded.

The prevailing view in Colorado courts is that broad exclusions for self-inflicted injuries or suicide attempts may not be applied in instances in which the insured or member was "insane" at the time of injury in sickness and accident policies written in Colorado. See e.g., Continental Casualty Co. v. Maguire, 471 P.2d 636 (Colo. Ct. App. 1970); Metropolitan Life Insur. Co. v. Wright, 480 P.2d 597 (Colo. Ct. App. 1971); Mass. Protective Ass'n v. Daugherty, 288 P. 888(Colo. 1930) (life insurance policy). The reasoning applied by these courts is that injuries sustained in such circumstances are "accidents," not "intentional" acts, since an individual who is insane is incapable of forming the requisite intent.

In addition, Federal HIPAA nondiscrimination provisions (see 29 CFR 2590.702(b)(2)(iii)) do not allow "source of injury" (i.e. self-inflicted) exclusions of benefits otherwise provided for treatment of an injury, if that injury results from a medical condition.

The Company's A4800W-CO policy forms state, in part, the following:

General Exclusions and Limitations

This policy does not cover any of the following expenses or charges:

- For expenses resulting from suicide, attempted suicide or self-inflicted illness or injury, while sane *or insane*. [Emphasis added.]

The Company's A3601-CO (1-97), A3603-CO (1-97), A3604-CO (1-97), and A2192-CO (1-99) policy forms state, in part, the following:

Exclusions

This policy does not cover:

- Expenses resulting from suicide or attempted suicide, whether sane *or insane*; [Emphasis added.]
- Expenses resulting from intentional self-inflicted injury.

The Company's A3605-CO (1-97) and A3606-CO (1-97) policy forms state, in part, the following:

Exclusions

This policy does not cover:

- Expenses resulting from suicide or attempted suicide;
- Expenses resulting from intentional self-inflicted injury.

The Company's A3800 policy form states, in part, the following:

Exclusions and Limitations

Part E.

- **WHAT WE WON'T PAY: We do not pay benefits for:**
    - Intentional, self-inflicted injuries.

Form	Form Number
Catastrophic Major Medical	A4800W-CO
Comprehensive Major Medical	A4800W-CO
Major Medical Policy	A3601-CO (1-97)
Major Medical Policy	A3603-CO (1-97)
Major Medical Policy	A3604-CO (1-97)
Major Medical Policy	A3605-CO (1-97)
Major Medical Policy	A3606-CO (1-97)
Short Term Major Medical Policy	A2192-CO (1-99)
Major Medical Policy	A3800

Recommendation No. 18:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-102, C.R.S. In the event the Company is unable to provide such documentation, it should be required to provide evidence to the Division that it has revised all affected policy forms to provide coverage for self-inflicted injuries, suicide, and attempted suicide to covered members that are insane as required by Colorado insurance law. The Company should also be required to conduct a self-audit to identify and correct any claims that may have been incorrectly denied due to this incorrect language, from January 1, 2008 to the present.

Issue E19: Failure, in some cases, to provide coverage for procedures that have been preauthorized.

Section 10-16-704, C.R.S., Network adequacy – rules – legislative declaration - repeal, states in part:

> (4) *When a treatment or procedure has been preauthorized by the plan, benefits cannot be retrospectively denied except for fraud and abuse.* If a health carrier provides preauthorization for treatment or procedures that are not covered benefits under the plan, the carrier shall provide the benefits as authorized with no penalty to the covered person. [Emphasis added.]

Colorado Division of Insurance Bulletin B-4.13, Preauthorization for Treatments or Procedures by Health Plans, states in part:

> I. Background and Purpose
>
> …Carriers often contract with third party to perform medical necessity or utilization review. The results of these reviews are often provided to the insureds or their providers before the carrier has made its coverage determination. In an attempt to reserve the right to make a subsequent coverage determination, the initial notification sometimes contains disclaimer language stating that coverage is contingent upon a subsequent level of review. After notification of approval at the initial review for medical necessity, some carriers are later denying coverage for the treatment or procedure which was the subject of the initial approval.
>
> …
>
> III. Division Position
>
> Colorado law states that once a carrier has "preauthorized" a treatment or procedure, the carrier cannot retrospectively deny the treatment of procedure, except for fraud and abuse, even where the benefit is not covered under the plan. See § 10-16-704(4), C.R.S. In addition, the statute prohibits the carrier from imposing a penalty on the insured for coverage of the benefit where the treatment or procedure was preauthorized. Covered persons and providers often do not distinguish between a medical necessity determination and a coverage determination, and act upon the initial medical necessity determination alone.
>
> To avoid any confusion between the types of determination, the Division interprets this statute to mean that whenever a treatment or procedure is approved, irrespective of the terminology used by the carrier when reviewing the claim (e.g., precertification, preauthorization, prior authorization, medical necessity or utilization review), the carrier cannot

> subsequently deny coverage. In other words, *it is incumbent upon the carrier to make its coverage determination prior to the delivery of any medical necessity determination or other form of preauthorization to the covered person or their provider.* The exceptions are for fraud and abuse or where the insured loses coverage after approval, but before actually obtaining the treatment or procedure. In addition, the carrier cannot reduce the benefit which was subject to the initial review in any manner, such as by requiring the insured to pay a higher co-pay than would normally be due under the plan.
>
> *Carriers cannot avoid the statutory requirement by including a disclaimer in the notice initially approving the treatment or procedure.* For example, a carrier cannot notify a provider and or insured that a particular treatment or procedure has passed a certain level of review, but final approval is contingent upon additional review. To do so is a violation of the intent of the statute to prohibit retrospective denials after "preauthorization." [Emphases added.]

It appears that the Company is not in compliance with Colorado insurance law in that its policy forms, in some cases, indicate that a preauthorization does not guarantee that a procedure will be covered. Colorado insurance law states that a treatment or procedure that has been preauthorized cannot be retrospectively denied except for fraud and abuse.

The Company's A3601-CO (1-97), A3603-CO (1-97), A3604-CO (1-97), A3605-CO (1-97), A3606-CO (1-97) and A2192-CO (1-99) policy forms state, in part, the following:

> **Precertification of Care**
>
> - Having a procedure precertified verifies medical necessity. *Precertification does not guarantee that a procedure is covered under this policy.* All other terms and conditions of this policy must be satisfied before the payment of benefits. [Emphasis added.]

Form	Form Number
Major Medical Policy	A3601-CO (1-97)
Major Medical Policy	A3603-CO (1-97)
Major Medical Policy	A3604-CO (1-97)
Major Medical Policy	A3605-CO (1-97)
Major Medical Policy	A3606-CO (1-97)
Short Term Major Medical Policy	A2192-CO (1-99)

Recommendation No. 19:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-704, C.R.S. In the event the Company is unable to provide such documentation, it should be required to provide evidence to the Division that it has revised all affected policy forms to ensure that coverage is provided for procedures that have been preauthorized as required by Colorado insurance law. The Company should also be required to conduct a self-audit to identify and correct any claims that may have been incorrectly denied due to this incorrect language, from January 1, 2008 to the present.

Issue E20: Failure, in some cases, to provide a clear indication of what is considered a complication of pregnancy and/or the complications of pregnancy definition included in the policy is overly restrictive.

Section 10-3-1104, C.R.S., Unfair methods of competition and unfair or deceptive acts or practices, states in part:

(1) The following are defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:

(a) Misrepresentations and false advertising of insurance policies: Making, issuing, circulating, or causing to be made, issued, or circulated, any estimate, circular, statement, sales presentation, omission, or comparison which:

(I) *Misrepresents the benefits*, advantages, *conditions*, or terms *of any insurance policy;* [Emphasis added.]

Section 10-16-104, C.R.S., Mandatory coverage provisions-definitions, states in part:

(2) Complications of pregnancy and childbirth.

(a) Any sickness and accident insurance policy providing indemnity for disability due to sickness issued by an entity subject to the provisions of part 2 of this article and any individual or group service or indemnity contract issued by an entity subject to part 3 of this article *shall provide coverage for a sickness or disease which is a complication of pregnancy or childbirth in the same manner as any other similar sickness or disease is otherwise covered under the policy or contract.* Any sickness and accident insurance policy providing indemnity for disability due to accident *shall provide coverage for an accident which occurs during the course of pregnancy or childbirth in the same manner as any other similar accident is covered under the policy.* [Emphasis added.]

Colorado Insurance Regulation 4-2-6, Concerning the Definition of the Term “Complications of Pregnancy”, states in part:

Section 4 Definitions

For the purposes of this regulation "complications of pregnancy" shall mean:

A. Conditions (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, physician-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, preeclampsia, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy;

B. Non-elective cesarean section, ectopic pregnancy, which is terminated, and spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible.

Section 5 Rules

All insurers marketing sickness and accident insurance policies, as defined in this regulation, delivered or issued for delivery in the State of Colorado shall use in each insurance policy or certificate of insurance a definition of the complications of pregnancy no more restrictive than that required by this regulation. [Emphasis added.]

It appears that the Company is not in compliance with Colorado insurance law in that its policy forms, in some cases, are not clear with regard to what is considered a complication of pregnancy and/or the complications of pregnancy definition included in the policy is overly restrictive. Specifically, the Company's policy forms, in some cases:

- Have premature labor listed in both the allowed and non-allowed sections of the definition, which may be misleading to the policyholder.

- Include hospital confinement as a requirement of a complication of pregnancy, which is not allowed by Colorado Insurance Regulation 4-2-6(5), as it is more restrictive than the definition in the regulation.

- Appear to indicate that only *acute* nephrosis is covered, which is more restrictive than the definition in Colorado Insurance Regulation 4-2-6 which states that nephrosis is covered with no requirement that it be considered acute.

- Indicate that only emergency cesarean sections are considered complications of pregnancy, which is in conflict with Colorado Insurance Regulation 4-2-6 where only non-elective cesarean sections are considered a complication of pregnancy.

- Indicate that complications of the fetus will not be considered a complication of pregnancy. It is the Division's position that complications of the fetus are considered conditions whose diagnosis is distinct from pregnancy but is adversely affected by pregnancy, and therefore should not be excluded from coverage.

- Are overly restrictive in that premature labor and threatened abortion require intravenous (IV) therapy in order to be considered a complication of pregnancy. It is the Division's position that premature labor and threatened abortion which are caused by conditions whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy are complications of pregnancy, and therefore the additional requirement to be treated by intravenous (IV) therapy is more restrictive than the requirements of Colorado Insurance Regulation 4-2-6.

Additionally, the policy forms, in some cases, do not include the coverage provisions required by § 10-16-104(2)(a), C.R.S., within the "Covered Benefits" section of the policy. Although the policy forms, in some cases, do indicate that complications of pregnancy are covered, within the listing of exclusions, in conjunction with the exclusion related to pregnancy and normal child birth, it is the Division's position that only including this language in the "Excluded Benefits" section is misleading. The mandated benefits required in § 10-16-104(2)(a), C.R.S., should be included within the "Covered Benefits" portion of the policy.

The Company's A4204 policy forms state, in part, the following:

Definitions

Complications of Pregnancy

- Complications of pregnancy include:
  - Conditions (when pregnancy is not terminated) that are caused by pregnancy or are distinct from pregnancy but are adversely affected by pregnancy, including but not limited to:
    - Severe dehydration requiring intravenous (IV) therapy;
    - *Acute nephritis or nephrosis*;
    - Cardiac decompensation;
    - *Premature labor* or threatened abortion *requiring intravenous (IV) therapy*; [Emphases added.]
    - Eclampsia; and
    - Abrupto previa.

  - Non-elective and medically necessary cesarean section, termination of ectopic pregnancy, and spontaneous termination of pregnancy occurring during a period of gestation in which a live birth is not possible.

- Complications of pregnancy shall not include conditions associated with the management of a difficult pregnancy, including but not limited to:
  - Elective cesarean section;
  - Antepartum or postpartum bleeding;
  - Morning sickness;
  - Genetic testing;
  - *Premature labor*; [Emphasis added.]
  - Placenta previa.

The Company's A4800W-CO policy forms state, in part, the following:

Definitions

Complications of Pregnancy

- Complications of pregnancy include any of the following:
  - Conditions (when pregnancy is not terminated) that are caused by pregnancy or are distinct from pregnancy but are adversely affected by pregnancy, including but not limited to:
    - Severe dehydration requiring intravenous (IV) therapy;
    - *Acute nephritis or nephrosis* ;
    - Cardiac decompensation;
    - Premature labor or threatened abortion;
    - Preeclampsia and eclampsia; and

        - Abrupto placentae or placenta previa.
    - *Emergency cesarean section*; [Emphases added.]
    - Termination of ectopic pregnancy; and
    - Spontaneous termination of pregnancy occurring during a period of gestation in which a live birth is not possible.

- The term Complications of pregnancy does not include any of the following:
    - Nonemergency cesarean sections including, but not limited to, either or both of the following:
        - *Cesarean sections that don't satisfy the definition of "Emergency Care" under this policy*; [Emphasis added.] and/or
        - Cesarean sections that are merely for the convenience of the patient or solely due to a previous cesarean section.
    - Conditions associated with the management of a difficult pregnancy including, but not limited to, any one or more of the following:
        - Postpartum bleeding unless it requires confinement in a hospital beyond the normal period of confinement for a normal childbirth;
        - Morning sickness;
        - Occasional spotting; and/or
        - False labor

The Company's A3601-CO (1-97), A3603-CO (1-97), A3604-CO (1-97), A3605-CO (1-97), A3606-CO (1-97) and A2192-CO (1-99) policy forms state, in part, the following:

Definitions

Complications of Pregnancy

- Complications of pregnancy include:
    - Conditions *requiring hospital confinement* (when pregnancy is not terminated) which are caused by pregnancy or are distinct from pregnancy but are adversely affected by pregnancy, including but not limited to :
        - Severe dehydration requiring intravenous (IV) therapy;
        - *Acute nephritis or nephrosis* ;
        - Cardiac decompensation;
        - *Premature labor* or threatened abortion *requiring intravenous (IV) therapy*; [Emphases added.]
        - Eclampsia; and
        - Abrupto previa.
    - Non-elective cesarean section, termination of ectopic pregnancy, and spontaneous termination of pregnancy occurring during a period of gestation in which a live birth is not possible.

- Complications of pregnancy shall not include conditions *which do not require hospital confinement* nor conditions associated with the management of a difficult pregnancy, including but not limited to :
    - Elective cesarean section;
    - Antepartum or postpartum bleeding;
    - *Premature labor*; [Emphases added.]
    - Morning sickness;

- Genetic testing;
- Placenta previa.

- *Complications of the fetus shall not be considered complications of pregnancy unless there are also complications of pregnancy arising out of the same condition*. [Emphasis added.]

The Company's A3800 policy form states, in part, the following:

Definitions

Part A.

- **Complications of Pregnancy:** Includes, but is not limited to: (1) conditions *requiring hospital confinement* (when the pregnancy is not terminated) whose diagnosis are distinct from pregnancy but adversely affected by pregnancy or are caused by pregnancy, such as: acute nephritis; nephrosis; cardiac decompensation; missed abortion; and similar medical and surgical conditions of comparable severity; (2) non-scheduled caesarean section delivery; ectopic pregnancy which is terminated; spontaneous termination of pregnancy that occurs during a period of gestation in which a viable birth is not possible; puerperal infection; eclampsia; and toxemia. It does not include: prescheduled caesarean section delivery; false labor; occasional spotting; physician prescribed rest during the period of pregnancy; morning sickness; hyperemesis gravidarum; or pre-eclampsia; and similar conditions associated with the management of a difficult pregnancy not constituting a medically diagnosed complication of pregnancy. [Emphasis added.]

Form	Form Number
Catastrophic Major Medical-PPO High Deductible	A4024
Catastrophic Major Medical-Non-PPO HSA	A4024
Catastrophic Major Medical-PPO HSA	A4024
Catastrophic Major Medical-PPO HSA with Optional Benefits	A4024
Comprehensive Major Medical-PPO High Deductible	A4024
Comprehensive Major Medical-Non-PPO HSA	A4204
Comprehensive Major Medical-PPO HSA	A4204
Comprehensive Major Medical-Non-PPO	A4204
Comprehensive Major Medical-All PPO Plans	A4204
Catastrophic Major Medical	A4800W-CO
Comprehensive Major Medical	A4800W-CO
Major Medical Policy	A3601-CO (1-97)
Major Medical Policy	A3603-CO (1-97)
Major Medical Policy	A3604-CO (1-97)
Major Medical Policy	A3605-CO (1-97)
Major Medical Policy	A3606-CO (1-97)
Short Term Major Medical Policy	A2192-CO (1-99)
Major Medical Policy	A3800

Recommendation No. 20:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §§ 10-3-1104, 10-16-104, C.R.S., and Colorado Insurance Regulation 4-2-6. In the event the Company is unable to provide such documentation, it should be required to provide evidence to the Division that it has revised all affected policy forms to include a definition of "complications of pregnancy" that is clear and not overly restrictive as required by Colorado insurance law. The Company should also be required to conduct a self-audit to identify and correct any claims that may have been incorrectly denied due to this incorrect language, from January 1, 2008 to the present.

Issue E21: Failure to provide a complete listing of forms within its annual certification of forms.

Section 10-16-107, C.R.S., Rate regulation - rules - approval of policy forms - benefit certificates - evidences of coverage - benefits ratio - disclosures on treatment of intractable pain, states in part:

> (2) *No policy of sickness and accident insurance* or subscription certificate or membership certificate or other evidence of health care coverage *shall be delivered or issued for delivery in this state, nor shall any endorsement, rider, or application that becomes a part of any such policy,* contract, or evidence of coverage *be used, until the insurer has filed a certification with the commissioner that such policy, endorsement, rider, or application conforms, to the best of the insurer's good faith knowledge and belief, to Colorado law pursuant to section 10-16-107.2, C.R.S.* and copies of the rates and the classification of risks or subscribers pertaining thereto are filed with the commissioner. [Emphasis added.]

Section 10-16-107.2, C.R.S., Filing of health policies, states in part:

> (1) *All sickness and accident insurers,* health maintenance organizations, and nonprofit hospital and health service corporations *authorized by the commissioner to conduct business in Colorado shall submit an annual report to the commissioner listing any policy form, endorsement, or rider for any sickness, accident,* nonprofit hospital and health service corporation, health maintenance organization, *or other health insurance policy, contract, certificate,* or other evidence of coverage *issued or delivered to any policyholder, certificate holder, enrollee, subscriber, or member in Colorado.…* [Emphasis added.]

It appears that the Company is not in compliance with Colorado insurance law in that its annual certification of forms was incomplete and did not list all of the forms that were in use at the time of the examination. The following forms were not included within the annual certification of forms as required:

<u>Form</u>	<u>Form Number</u>
Wellness Benefit Rider	R1180
Wellness Benefit Rider	R1180-P
Outpatient Accident Benefit Rider	R1148
Outpatient Accident Benefit Rider	R1148-CO
Refund of Premium for Good Health	R1246
Cancer Benefit Rider	R1153-ind.

<u>Recommendation No. 21:</u>

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §§ 10-16-107 and 10-16-107.2, C.R.S. In the event the Company is unable to provide such documentation, it should be required to provide evidence that it has established procedures to ensure that all forms in use during a particular year are reported on the annual report of forms as required by Colorado insurance law.

Issue E22: Failure to ensure that all forms certified by the Company were in compliance with Colorado insurance law.

Section 10-3-1104, C.R.S., Unfair methods of competition and unfair or deceptive acts or practices, states in part:

(1) The following are defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:

(s) *Certifying pursuant to section 10-16-107.2 or issuing, soliciting, or using a policy form, endorsement, or rider that does not comply with statutory mandates.* Such solicitation or certification shall be subject to the sanctions described in sections 10-2-704, 10-2-801, 10-2-804, 10-3-1107, 10-3-1108, and 10-3-1109. [Emphasis added.]

It appears that the Company is not in compliance with Colorado insurance law in that not all forms that were certified and used by the Company were in compliance with statutory mandates as evidenced by Issues E1 – E20, E23 – E33

Form	Form Number
Catastrophic Major Medical-PPO High Deductible	A4024
Catastrophic Major Medical-Non-PPO HSA	A4024
Catastrophic Major Medical-PPO HSA	A4024
Catastrophic Major Medical-PPO HSA with Optional Benefits	A4024
Comprehensive Major Medical-PPO High Deductible	A4024
Comprehensive Major Medical-Non-PPO HSA	A4204
Comprehensive Major Medical-PPO HSA	A4204
Comprehensive Major Medical-Non-PPO	A4204
Comprehensive Major Medical-All PPO Plans	A4204
Catastrophic Major Medical	A4800W-CO
Comprehensive Major Medical	A4800W-CO
State Mandated Benefits Rider	R4800W-CO

Major Medical Policy	A3601-CO (1-97)
Major Medical Policy	A3603-CO (1-97)
Major Medical Policy	A3604-CO (1-97)
Major Medical Policy	A3605-CO (1-97)
Major Medical Policy	A3606-CO (1-97)
Short Term Major Medical Policy	A2192-CO (1-99)
Major Medical Policy	A3800

Recommendation No. 22:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-3-1104, C.R.S. In the event the Company is unable to provide such documentation, it should be required to provide evidence that it has established procedures to ensure that policy forms certified as compliant by an officer of the company are in compliance with statutory mandates as required by Colorado insurance law.

Issue E23: Failure, in some cases, to provide coverage to newborns or children placed for adoption for the first thirty-one (31) days from the date of birth or placement unless premium is paid.

Section 10-16-104, C.R.S., Mandatory coverage provisions-definitions, states in part:

(1) Newborn children.

(a) *All* group and *individual sickness and accident insurance policies* and all service or indemnity contracts issued by any entity subject to part 3 or 4 of this article *shall provide coverage for a dependent newborn child of the insured or subscriber from the moment of birth.* [Emphasis added.]

…

(c)(I) *…the benefits available to newborn children shall consist of coverage of injury or sickness, including all medically necessary care and treatment of medically diagnosed congenital defects and birth abnormalities for the first thirty-one days of the newborn's life, notwithstanding policy limitations and exclusions applicable to other conditions or procedures covered by the policy.* Except as provided in sub-subparagraph (C) of subparagraph (II) of this paragraph (c), such coverage shall be subject to copayment, deductible, and aggregate dollar policy maximums that are no higher than are generally applicable under the policy to all other sicknesses, diseases, and conditions otherwise covered under the policy. [Emphasis added.]

…

(6.5) Adopted child – dependent coverage.

(a) Whenever an entity described in paragraph (a) of subsection (6) of this section offers coverage for dependent children under a health plan, *the entity shall provide benefits to a child placed for adoption with an enrollee, policyholder, or subscriber under the same terms and conditions that apply to a natural dependent of an enrollee, policyholder, or subscriber, regardless of whether adoption of the child is final*. [Emphasis added.]

Colorado Insurance BulletinB-4.6, concerning Mandatory Newborn Coverage and Premiums, states in part:

(III) Division Position

(A) Coverage during the first 31 days:

Coverage must be provided automatically upon birth, continuing through the thirty-first day, without requiring notification or payment of premium. Such coverage shall be provided for the first thirty-one days of life and shall include all coverage available under the policy,…[Emphasis added.]

It appears that the Company is not in compliance with Colorado insurance law in that its policy forms require that premium be paid in order for a newborn to be covered within the first thirty-one (31) days from the date of birth. Additionally, its policy forms require that premium be paid in order for an adopted child to be covered within the first thirty-one (31) days from the date of placement. Colorado insurance law requires that newborns be covered automatically for the first thirty-one (31) days of a newborn's life and that adopted children be covered for the first thirty-one (31) days after placement regardless if premium is paid. Premium would only be required to continue coverage for the newborn and/or adopted child beyond the first thirty-one (31) days.

The Company's A4024, A3601-CO (1-97), A3603-CO (1-97), A3604-CO (1-97), A3605-CO (1-97), A3606-CO (1-97), and A2192-CO (1-99) policy forms state, in part (with minor variances) the following:

Policy Provisions:

- Policy Date:
  - Your newborn child(ren) is covered for 31 days from the date of birth, *provided you send us the required premium*.
  - Your adopted child(ren) is covered for the first 31 days after the date of placement, *provided you send us the required premium*. [Emphases added.]

Form	Form Number
Catastrophic Major Medical-PPO High Deductible	A4024
Catastrophic Major Medical-Non-PPO HSA	A4024
Catastrophic Major Medical-PPO HSA	A4024
Catastrophic Major Medical-PPO HSA with Optional Benefits	A4024
Comprehensive Major Medical-PPO High Deductible	A4024
Comprehensive Major Medical-Non-PPO HSA	A4204
Comprehensive Major Medical-PPO HSA	A4204
Comprehensive Major Medical-Non-PPO	A4204
Comprehensive Major Medical-All PPO Plans	A4204
Major Medical Policy	A3601-CO (1-97)
Major Medical Policy	A3603-CO (1-97)
Major Medical Policy	A3604-CO (1-97)
Major Medical Policy	A3605-CO (1-97)
Major Medical Policy	A3606-CO (1-97)
Short Term Major Medical Policy	A2192-CO (1-99)

Recommendation No. 23:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-104, C.R.S. In the event the Company is unable to provide such documentation, it should be required to provide evidence to the Division that it has revised all affected policy forms to provide coverage to newborns and children placed for adoption for the first thirty-one (31) days from the date of birth or placement, regardless of whether or not premium is paid, as required by Colorado insurance law. The Company should also be required to conduct a self-audit to identify and refund any premiums that may have been inappropriately denied due to this incorrect language, from January 1, 2008 to the present.

Issue E24: Failure, in some cases, to provide coverage related to any organ, system, or part/area of the body that the Company deems necessary.

Section 10-3-1104, C.R.S., Unfair methods of competition and unfair or deceptive acts or practices, states in part:

(1) The following are defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:

(f) Unfair discrimination:

(XI) Reducing benefits under a health insurance policy by the addition of an exclusionary rider, *unless such rider only excludes conditions which have been documented in the original underwriting application, original underwriting medical examination, or medical history of the insured, or which can be shown with clear and convincing evidence to have been caused by the medically documented excluded condition;* [Emphasis added.]

It appears that the Company is not in compliance with Colorado insurance law in that its policy forms, in some cases, are overly restrictive in that they exclude coverage for any organ, system, or part/area of the body that the Company deems necessary. Colorado insurance law does not allow a health carrier to reduce benefits under a health insurance policy by the addition of an exclusionary rider unless such rider only excludes *conditions* which have been documented in the original underwriting application, original underwriting medical examination, or medical history of the insured, or which can be shown with clear and convincing evidence to have been caused by the medically documented excluded condition. Exclusions of organs, systems, body parts, or conditions that are overly broad and extend beyond the condition identified in the underwriting examination or medical history are not allowed.

The Company's A4204 policy forms state, in part, the following:

Coverage Exclusions:

- We reserve the right to exclude from coverage by name or specific description, any condition *or any organ, system, part or area of the body, as we deem necessary*, based on a person's health history. *We may require you to sign an amendment to this policy that specifically excludes from coverage the condition or the organ, system, part or area of the body, as applicable to you, your spouse or your dependent children. We further reserve the right to decline to insure you, your spouse, or your dependent child(ren), if you do not sign the amendment to this policy.* [Emphasis added.]

The Company's A4800W-CO policy forms state, in part, the following:

Coverage Exclusions:

- *We reserve the right to exclude from coverage by name or specific description any condition or any organ, system, part or area of the body,* or high risk activity *as we deem necessary. We may require you to sign an amendment to this policy that specifically excludes from coverage the condition or the organ, system, part or area of the body,* or high risk activity, *as applies to you,*

> *your spouse, or your other dependents. We further reserve the right to decline to insure you, your spouse, or your other dependents if you do not sign the amendment to this policy.* [Emphasis added.]

Form	Form Number
Catastrophic Major Medical-PPO High Deductible	A4024
Catastrophic Major Medical-Non-PPO HSA	A4024
Catastrophic Major Medical-PPO HSA	A4024
Catastrophic Major Medical-PPO HSA with Optional Benefits	A4024
Comprehensive Major Medical-PPO High Deductible	A4024
Comprehensive Major Medical-Non-PPO HSA	A4204
Comprehensive Major Medical-PPO HSA	A4204
Comprehensive Major Medical-Non-PPO	A4204
Comprehensive Major Medical-All PPO Plans	A4204
Catastrophic Major Medical	A4800W-CO
Comprehensive Major Medical	A4800W-CO

Recommendation No. 24:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-3-1104, C.R.S. In the event the Company is unable to provide such documentation, it should be required to provide evidence to the Division that it has revised all affected policy forms to remove any exclusion prohibited by Colorado insurance law. The Company should also be required to conduct a self-audit to identify and correct any claims that may have been incorrectly denied due to this incorrect language, from January 1, 2008 to the present.

Issue E25: Failure, in some cases, to provide coverage for services or treatment related to certain "high risk" activities.

Section 10-3-1104, C.R.S., Unfair methods of competition and unfair or deceptive acts or practices, states in part:

(1) The following are defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:

(f) Unfair discrimination:

(XII) Denying health care coverage subject to article 16 of this title to any individual *based solely on that individual's casual or nonprofessional participation in the following activities: Motorcycling; snowmobiling; off-highway vehicle riding; skiing; or snowboarding.* [Emphasis added.]

It appears that the Company is not in compliance with Colorado insurance law in that its policy forms, in some cases, include an exclusion for high risk activities that is overly broad and restrictive in that the policy forms do not define what is considered to be a high risk activity. Colorado insurance law prohibits denying health care coverage based solely on an individual's casual or nonprofessional participation in certain activities that some may consider "high risk" such as motorcycling, snowmobiling, off-highway vehicle riding, skiing, or snowboarding.

The Company's A4800W-CO policy forms state, in part, the following:

Coverage Exclusions:

- *We reserve the right to exclude from coverage by name or specific description any* condition or any organ, system, part or area of the body, or *high risk activity as we deem necessary. We may require you to sign an amendment to this policy that specifically excludes from coverage the* condition or the organ, system, part or area of the body, or *high risk activity*, a*s applies to you, your spouse, or your other dependents. We further reserve the right to decline to insure you, your spouse, or your other dependents if you do not sign the amendment to this policy.* [Emphasis added.]

Form	Form Number
Catastrophic Major Medical	A4800W-CO
Comprehensive Major Medical	A4800W-CO

Recommendation No. 25:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-3-1104, C.R.S. In the event the Company is unable to provide such documentation, it should be required to provide evidence to the Division that it has revised all affected policy forms to remove any exclusion prohibited by Colorado insurance law. The Company should also be required to conduct a self-audit to identify and correct any claims that may have been incorrectly denied due to this incorrect language, from January 1, 2008 to the present.

Issue E26: Failure to specifically include the required coverage for newborn hospital stays.

Section 10-16-104, C.R.S., Mandatory coverage provisions-definitions, states in part:

(1) Newborn children.

(b)(I) Coverage for a hospital stay for a newborn following a normal vaginal delivery shall not be limited to less than forty-eight hours. If forty-eight hours following delivery falls after 8 p.m., coverage shall continue until 8 a.m. the following morning.

(II) Coverage for a hospital stay for a newborn following a cesarean section shall not be limited to less than ninety-six hours. If ninety-six hours following the cesarean section falls after 8 p.m., coverage shall continue until 8 a.m. the following morning.

It appears that the Company is not in compliance with Colorado insurance law in that its policy forms do not specifically include the required coverage for newborn hospital stays stipulated in subparagraphs (I) and (II) of § 10-16-104(1)(b), C.R.S. It is the Division's position that these benefits should be specifically included within each policy form.

Form	Form Number
Catastrophic Major Medical-PPO High Deductible	A4024
Catastrophic Major Medical-Non-PPO HSA	A4024
Catastrophic Major Medical-PPO HSA	A4024
Catastrophic Major Medical-PPO HSA with Optional Benefits	A4024
Comprehensive Major Medical-PPO High Deductible	A4024
Comprehensive Major Medical-Non-PPO HSA	A4204
Comprehensive Major Medical-PPO HSA	A4204
Comprehensive Major Medical-Non-PPO	A4204
Comprehensive Major Medical-All PPO Plans	A4204
Catastrophic Major Medical	A4800W-CO
Comprehensive Major Medical	A4800W-CO
Major Medical Policy	A3601-CO (1-97)
Major Medical Policy	A3603-CO (1-97)
Major Medical Policy	A3604-CO (1-97)
Major Medical Policy	A3605-CO (1-97)
Major Medical Policy	A3606-CO (1-97)
Short Term Major Medical Policy	A2192-CO (1-99)
Major Medical Policy	A3800

Recommendation No. 26:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-104, C.R.S. In the event the Company is unable to provide such documentation, it should be required to provide evidence to the Division that it has revised all affected policy forms to specifically include the required coverage for newborn hospital stays as required by Colorado insurance law. The Company should also be required to conduct a self-audit to identify and correct any claims that may have been incorrectly denied due to this incorrect language, from January 1, 2008 to the present.

Issue E27: Failure, in some cases, to include the mandatory coverage for inherited enzymatic disorders.

Section 10-16-104, C.R.S., Mandatory coverage provisions-definitions, states in part:

(1) Newborn children.

(a) *All* group and *individual sickness and accident insurance policies* and all service or indemnity contracts issued by any entity subject to part 3 or 4 of this article *shall provide coverage for a dependent newborn child of the insured or subscriber from the moment of birth.* [Emphasis added.]

…

(c)(III)(A) *Coverage for inherited enzymatic disorders* caused by single gene defects involved in the metabolism of amino, organic, and fatty acids *shall include, but not be limited to, the following diagnosed conditions: Phenylketonuria; maternal phenylketonuria; maple syrup urine disease; tyrosinemia; homocystinuria; histidinemia; urea cycle disorders; hyperlysinemia; glutaric acidemias; methylmalonic acidemia; and propionic acidemia. Covered care and treatment of such conditions shall include, to the extent medically necessary, medical foods for home use for which a physician who is a participating provider has issued a written, oral, or electronic prescription.* [Emphasis added.]

It appears that the Company is not in compliance with Colorado insurance law in that its policy forms, in some cases, do not include the mandatory coverage for inherited enzymatic disorders required by § 10-16-104(1)(c)(III)(A), C.R.S.

Form	Form Number
Catastrophic Major Medical	A4800W-CO
Comprehensive Major Medical	A4800W-CO
Major Medical Policy	A3601-CO (1-97)
Major Medical Policy	A3603-CO (1-97)
Major Medical Policy	A3604-CO (1-97)
Major Medical Policy	A3605-CO (1-97)
Major Medical Policy	A3606-CO (1-97)
Short Term Major Medical Policy	A2192-CO (1-99)
Major Medical Policy	A3800

Recommendation No. 27:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-104, C.R.S. In the event the Company is unable to provide such documentation, it should be required to provide evidence to the Division that it has revised all affected policy forms to include the mandatory coverage for inherited enzymatic disorders as required by Colorado insurance law. The Company should also be required to conduct a self-audit to identify and correct any claims that may have been incorrectly denied due to this incorrect language, from January 1, 2008 to the present.

Issue E28: Failure, in some cases, to apply the appropriate timeframes related to when premium can be accepted in connection with a reinstatement, and to use the statutorily-mandated language as required.

Section 10-16-202, C.R.S., Required provisions in individual sickness and accident policies, states in part:

(1) Except as provided in section 10-16-204, C.R.S., each such policy delivered or issued for delivery to any person in this state shall contain the provisions specified in this section in the words in which the same appear in this section; except that the insurer, at its option, may substitute for one or more of such provisions corresponding provisions of different wording approved by the commissioner which are in each instance not less favorable in any respect to the insured or the beneficiary. Such provisions shall be preceded individually by the caption appearing in this section or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the commissioner may approve.

…

(5)(a) A provision as follows: "Reinstatement: If any renewal premium is not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by any agent duly authorized by the insurer to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy. If the insurer or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the insurer or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten days after such date. In all other respects the insured and insurer shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. *Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than sixty days prior to the date of reinstatement."* [Emphasis added.]

It appears that the Company is not in compliance with Colorado insurance law in that its policy forms, in some cases, do not include the statutorily-required language as noted above. Additionally, the forms require that all of the premiums due since the date of lapse be paid in order to reinstate a policy. Colorado law stipulates that any premium accepted in connection with a reinstatement can be applied to a period for which premium has not been previously paid, but not to any period more than *sixty days* prior to the date of reinstatement. Therefore, the premium required to be paid in order to reinstate a policy should not exceed the amount due for sixty (60) days prior to the date of reinstatement.

The Company's A4204, A4800W-CO policy forms state, in part, (with minor variances) the following:

Policy Provisions

Reinstatement Provision:

- Reinstating a lapse policy puts it back in force so it will again provide coverage. *You must pay us all the premiums due since the date of lapse to put this policy back in force.* If we later accept your premium and do not require an application for reinstatement, that payment will reinstate the policy. If we require an application for reinstatement (we will give you a receipt for the premium you paid), this policy will be put back in force when we approve it. If we fail to notify you of disapproval within 45 days of the date of receipt, your policy will be put back in force on that 45th day. Your reinstated policy will cover only loss due to accidental injuries received after the date this policy was put back in force. Also, it will cover only loss due to illness that starts more than 10 days after the date this policy was put back in force. In all other respects, you and we will have the same rights under this policy that you and we had before it lapsed, unless there are special conditions that apply to the reinstatement. If there are, they will be endorsed on or attached to this policy. [Emphasis added.]

  Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

The Company's A3601-CO (1-97), A3603-CO (1-97), A3604-CO (1-97), A3605-CO (1-97), A3606-CO (1-97) and A3800 policy forms state, in part, the following:

Policy Provisions

Reinstatement Provision:

- Reinstating a lapse policy puts it back in force so it will again provide coverage. *You must pay us all the premiums due since the date of lapse to put this policy back in force.* [Emphasis added.]

  If we later accept your premium and do not require an application for reinstatement, that payment will reinstate the policy. If we require an application for reinstatement (we will give you a receipt for the premium you paid), this policy will be put back in force when we approve it. If we fail to notify you of disapproval within 45 days of the date of receipt, your policy will be put back in force on that 45th day.

  Your reinstated policy will cover only loss due to accidental injuries received after the date this policy was put back in force. Also, it will cover only loss due to illness that starts more than 10 days after the date this policy was put back in force.

  In all other respects, you and we will have the same rights under this policy that you and we had before it lapsed, unless there are special conditions that apply to the reinstatement. If there are, they will be endorsed on or attached to this policy.

Form	Form Number
Catastrophic Major Medical-PPO High Deductible	A4024
Catastrophic Major Medical-Non-PPO HSA	A4024
Catastrophic Major Medical-PPO HSA	A4024
Catastrophic Major Medical-PPO HSA with Optional Benefits	A4024
Comprehensive Major Medical-PPO High Deductible	A4024
Comprehensive Major Medical-Non-PPO HSA	A4204
Comprehensive Major Medical-PPO HSA	A4204
Comprehensive Major Medical-Non-PPO	A4204
Comprehensive Major Medical-All PPO Plans	A4204
Catastrophic Major Medical	A4800W-CO
Comprehensive Major Medical	A4800W-CO
Major Medical Policy	A3601-CO (1-97)
Major Medical Policy	A3603-CO (1-97)
Major Medical Policy	A3604-CO (1-97)
Major Medical Policy	A3605-CO (1-97)
Major Medical Policy	A3606-CO (1-97)
Major Medical Policy	A3800

Recommendation No. 28:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-202, C.R.S. In the event the Company is unable to provide such documentation, it should be required to provide evidence to the Division that it has revised all affected policy forms to reflect the appropriate timeframes related to when premium can be accepted in connection with a reinstatement as required by Colorado insurance law.

Issue E29: Failure, in some cases, to clearly disclose the existence and availability of an access plan. *This appears to be a repeat issue that was identified as issue E4 during the last market conduct exam of this Company, which was completed on June 11, 2004 covering the period of January 1, 2003 to December 31, 2003.*

Section 10-16-704, C.R.S., Network adequacy – rules – legislative declaration - repeal, states in part:

> (9) Beginning January 1, 1998, a carrier shall maintain and make available upon request of the commissioner, the executive director of the department of public health and environment, or the executive director of the department of health care policy and financing, in a manner and form that reflects the requirements specified in paragraphs (a) to (k) of this subsection (9), an access plan for each managed care network that the carrier offers in this state. The carrier shall make the access plans, absent confidential information as specified in section 24-72-204 (3), C.R.S., available on its business premises and shall provide them to any interested party upon request. *In addition, all health benefit plans and marketing materials shall clearly disclose the existence and availability of the access plan.* All rights and responsibilities of the covered person under the health benefit plan, however, shall be included in the contract provisions, regardless of whether or not such provisions are also specified in the access plan… [Emphasis added.]

It appears that the Company is not in compliance with Colorado insurance law in that its policy forms, in some cases, do not clearly disclose the existence and availability of an access plan as required by § 10-16-704(9), C.R.S.

Form	Form Number
Catastrophic Major Medical	A4800W-CO
Comprehensive Major Medical	A4800W-CO
Major Medical Policy	A3601-CO (1-97)
Major Medical Policy	A3603-CO (1-97)
Major Medical Policy	A3604-CO (1-97)
Major Medical Policy	A3605-CO (1-97)
Major Medical Policy	A3606-CO (1-97)
Major Medical Policy	A3800

Recommendation No. 29:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-704, C.R.S. In the event the Company is unable to provide such documentation, it should be required to provide evidence to the Division that it has revised all affected policy forms to clearly disclose the existence and availability of an access plan as required by Colorado insurance law.

Issue E30: Failure, in some cases, to include the mandatory language regarding claim forms.

Section 10-16-202, C.R.S., Required provisions in individual sickness and accident policies, states in part:

(1) Except as provided in section 10-16-204, C.R.S., each such policy delivered or issued for delivery to any person in this state shall contain the provisions specified in this section in the words in which the same appear in this section; except that the insurer, at its option, may substitute for one or more of such provisions corresponding provisions of different wording approved by the commissioner which are in each instance not less favorable in any respect to the insured or the beneficiary. Such provisions shall be preceded individually by the caption appearing in this section or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the commissioner may approve.

…

(7) A provision as follows: "Claim forms: The insurer, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within fifteen days after the giving of such notice, the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character, and the extent of the loss for which claim is made."

It appears that the Company is not in compliance with Colorado insurance law in that its policy forms, in some cases, do not include the mandatory language regarding claim forms as required by 10-16-202(7), C.R.S.

Form	Form Number
Major Medical Policy	A3601-CO (1-97)
Major Medical Policy	A3603-CO (1-97)
Major Medical Policy	A3604-CO (1-97)
Major Medical Policy	A3605-CO (1-97)
Major Medical Policy	A3606-CO (1-97)
Short Term Major Medical Policy	A2192-CO (1-99)

Recommendation No. 30:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-202, C.R.S. In the event the Company is unable to provide such documentation, it should be required to provide evidence to the Division that it has revised all affected policy forms to include the mandatory language regarding claim forms as required by Colorado insurance law.

Issue E31: Failure to reflect the appropriate adjustments that are to be made when a misstatement of age or sex occurs.

Section 10-16-203, C.R.S., Optional provisions in individual sickness and accident policies, states in part:

(1) *Except as provided in section 10-16-204, C.R.S., no individual sickness and accident insurance policy delivered or issued for delivery to any person in this state shall contain provisions respecting the matters set forth below unless such provisions are in the words in which the same appear in this section;* except that the insurer may, at its option, use in lieu of any such provision a corresponding provision of different wording approved by the commissioner which is not less favorable in any respect to the insured or the beneficiary. Any such provision contained in the policy shall be preceded individually by the appropriate caption appearing in this section or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the commissioner may approve. [Emphasis added.]

…

(3) *A provision as follows: "Misstatement of age: If the age of the insured has been misstated, all amounts payable under this policy shall be such as the premium paid would have purchased at the correct age."* [Emphasis added.]

It appears that the Company is not in compliance with Colorado insurance law in that its policy forms indicate that if the age of the covered person has been misstated an adjustment to the premium and/or benefits could occur. Colorado insurance law stipulates that if the age of the insured has been misstated, only a *benefit* adjustment can be made on a retrospective basis. Additionally, policy form A3800 indicates that the premium and/or benefits could be adjusted based on the misstatement of the sex of the insured, which would be more restrictive than what is allowed under 10-16-203(3), C.R.S. Premiums may only be adjusted on a forward-going basis, once a misstatement of age or an incorrectly disclosed rating factor has been identified.

The Company's A4204 and A4800W-CO policy forms state, in part, the following:

Policy Provisions

Misstatement of Age:

- If the age of any covered person has been misstated, *the premiums may be adjusted*. If the amount of insurance would be affected by such misstatement, it will be changed to the amount the covered person would have had at the correct age, *and the premium will be based on the corrected age and amount*. [Emphasis added.]

The Company's A3601-CO (1-97), A3603-CO (1-97), A3604-CO (1-97), A3605-CO (1-97), A3606-CO (1-97) and A2192-CO (1-99) policy forms state, in part, the following:

Policy Provisions

Correcting Misstatements:

- If any relevant fact about the covered person has been misstated, the true facts will be used to determine whether insurance is inforce. If the age of any covered person has been misstated, *an adjustment in premium* or benefits, *or both,* will be made based on the true facts. No misstatement of age will continue insurance otherwise terminated or terminate insurance otherwise inforce. [Emphasis added.]

The Company's A3800 policy form states, in part, the following:

Payment of Claims

Misstatement of Age or Sex:

- If a covered person's age or *sex* has been misstated, the benefits may be adjusted, based on the relationship of the premium paid to the premium that should have been paid based on the correct age and *sex*. [Emphasis added.]

Form	Form Number
Catastrophic Major Medical-PPO High Deductible	A4024
Catastrophic Major Medical-Non-PPO HSA	A4024
Catastrophic Major Medical-PPO HSA	A4024
Catastrophic Major Medical-PPO HSA with Optional Benefits	A4024
Comprehensive Major Medical-PPO High Deductible	A4024
Comprehensive Major Medical-Non-PPO HSA	A4204
Comprehensive Major Medical-PPO HSA	A4204
Comprehensive Major Medical-Non-PPO	A4204
Comprehensive Major Medical-All PPO Plans	A4204
Catastrophic Major Medical	A4800W-CO
Comprehensive Major Medical	A4800W-CO
Major Medical Policy	A3601-CO (1-97)
Major Medical Policy	A3603-CO (1-97)
Major Medical Policy	A3604-CO (1-97)
Major Medical Policy	A3605-CO (1-97)
Major Medical Policy	A3606-CO (1-97)
Short Term Major Medical Policy	A2192-CO (1-99)
Major Medical Policy	A3800

Recommendation No. 31:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-203, C.R.S. In the event the Company is unable to provide such documentation, it should be required to provide evidence to the Division that it has revised all affected policy forms to reflect the appropriate adjustments that are made when a misstatement of age or sex occurs as required by Colorado insurance law. The Company should also be required to conduct a self-audit to identify and correct any claims that may have been incorrectly denied due to this incorrect language, from January 1, 2008 to the present.

Issue E32: Failure, in some cases, to include the mandatory coverage for hospitalization and general anesthesia for dental procedures for dependent children.

Section 10-16-104, C.R.S., Mandatory coverage provisions-definitions, states in part:

(12) Hospitalization and general anesthesia for dental procedures for dependent children.

(a) *All individual and all group sickness and accident insurance policies that are delivered or issued for delivery within the state by an entity subject to the provisions of part 2 of this article* and all individual and group health care service or indemnity contracts issued by an entity subject to the provisions of part 3 or 4 of this article except supplemental policies that cover a specific disease or other limited benefit *shall provide coverages for general anesthesia, when rendered in a hospital, outpatient surgical facility, or other facility licensed pursuant to section 25-3-101, C.R.S., and for associated hospital or facility charges for dental care provided to a dependent child, as dependent is defined in section 10-16-102 (14), of a covered person.…*[Emphasis added.]

It appears that the Company is not in compliance with Colorado insurance law in that its policy forms, in some instances, do not include the mandatory coverage for hospitalization and general anesthesia for dental procedures for dependent children as required by § 10-16-104(12)(a), C.R.S.

Form	Form Number
Major Medical Policy	A3601-CO (1-97)
Major Medical Policy	A3603-CO (1-97)
Major Medical Policy	A3604-CO (1-97)
Short Term Major Medical Policy	A2192-CO (1-99)
Major Medical Policy	A3800

Recommendation No. 32:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-104, C.R.S. In the event the Company is unable to provide such documentation, it should be required to provide evidence to the Division that it has revised all affected policy forms to include the mandatory coverage for hospitalization and general anesthesia for dental procedures for dependent children as required by Colorado insurance law. The Company should also be required to conduct a self-audit to identify and correct any claims that may have been incorrectly denied due to this incorrect language, from January 1, 2008 to the present.

Issue E33: Failure, in some cases, to include the mandatory coverage for diabetes.

Section 10-16-104, C.R.S., Mandatory coverage provisions-definitions, states in part:

> (13) Diabetes.
>
> (a) *Any health benefit plan,* except supplemental policies covering a specified disease or other limited benefit, that provides hospital, surgical, or medical expense insurance shall provide coverage for diabetes that *shall include equipment, supplies, and outpatient self-management training and education, including medical nutrition therapy if prescribed by a health care provider licensed to prescribe such items pursuant to Colorado law, and, if coverage is provided through a managed care plan, such qualified provider shall be a participating provider in such managed care plan.* [Emphasis added.]

It appears that the Company is not in compliance with Colorado insurance law in that its policy forms, in some instances, do not include the mandatory coverage for diabetes as required by § 10-16-104(13)(a), C.R.S.

Form	Form Number
Major Medical Policy	A3601-CO (1-97)
Major Medical Policy	A3603-CO (1-97)
Major Medical Policy	A3604-CO (1-97)
Short Term Major Medical Policy	A2192-CO (1-99)
Major Medical Policy	A3800

<u>Recommendation No. 33:</u>

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-104, C.R.S. In the event the Company is unable to provide such documentation, it should be required to provide evidence to the Division that it has revised all affected policy forms to include the mandatory coverage for diabetes as required by Colorado insurance law. The Company should also be required to conduct a self-audit to identify and correct any claims that may have been incorrectly denied due to this incorrect language, from January 1, 2008 to the present.

CLAIMS

Issue J1:	**Failure, in some cases, to pay, deny or settle claims within the timeframes required by Colorado insurance law.**

Section 10-16-106.5, C.R.S., Prompt payment of claims – legislative declaration, states in part:

(2) *As used in this section, "clean claim" means a claim for payment of health care expenses that is submitted to a carrier on the uniform claim form adopted pursuant to section 10-16-106.3 with all required fields completed with correct and complete information, including all required documents.* A claim requiring additional information shall not be considered a clean claim and shall be paid, denied or settled as set forth in paragraph (b) of subsection (4) of this section. "Clean claim" does not include a claim for payment of expenses incurred during a period of time for which premiums are delinquent, except to the extent otherwise required by law.

…

(4)(a) *Clean claims shall be paid, denied, or settled within thirty calendar days after receipt by the carrier if submitted electronically* and within forty-five calendar days after receipt by the carrier if submitted by any other means.

…

(c) *Absent fraud, all claims except those described in paragraph (a) of this subsection (4) shall be paid, denied, or settled within ninety calendar days after receipt by the carrier.* [Emphases added.]

Clean Electronic Claims Over 30 Days – Late Adjudication

Population	Sample Size	Number of Exceptions	Percentage to Sample
5,002	107	21	20%

The examiner reviewed a sample of 107 claims selected from a total population of 5,002 claims that had been received electronically and were not paid, denied or settled within thirty (30) calendar days. It appears that the Company is not in compliance with Colorado insurance law in that twenty-one (21) claims in the sample appeared to represent clean claims, but were not paid, denied, or settled within the required time period.

Clean Non-Electronic Claims Over 45 Days – Late Adjudication

Population	Sample Size	Number of Exceptions	Percentage to Sample
680	105	49	47%

It appears that the Company is not in compliance with Colorado insurance law in that forty-nine (49) of 105 non-electronic claims randomly selected from the total population of 680 claims adjudicated more than forty-five (45) days after receipt appeared to be clean claims and were not paid, denied or settled within the required time frame.

Over Ninety (90) Day Claims--Timeliness

Population	Sample Size	Number of Exceptions	Percentage to Sample
1,174	107	67	63%

The examiner reviewed a random sample of 107 claims selected from a total population of 1,174 claims that were paid, denied or settled in excess of ninety (90) days during the period under examination. It appears the Company is not in compliance with Colorado insurance law in that the Company failed to pay, deny or settle sixty-seven (67) of the 107 reviewed claims within the required ninety (90) calendar days. There was no indication in the claim records that any of the cited claims involved fraud. Absent fraud, all claims are to be paid, denied, or settled within ninety (90) calendar days of receipt.

Recommendation No. 34:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-106.5, C.R.S. In the event the Company is unable to provide such documentation, it should provide evidence to the Division that it has established procedures to ensure that all claims are paid, denied or settled within the time periods required by Colorado insurance law.

Issue J2:	**Failure, in some cases, to pay the appropriate penalty payment to the insured or health care provider on the ninety-first day after receipt of the claim by the carrier.**

Section 10-16-106.5, C.R.S., Prompt payment of claims – legislative declaration, states in part:

(4)(a) Clean claims shall be paid, denied, or settled within thirty calendar days after receipt by the carrier if submitted electronically and within forty-five calendar days after receipt by the carrier if submitted by any other means.

…

(c) *Absent fraud, all claims except those described in paragraph (a) of this subsection (4) shall be paid, denied, or settled within ninety calendar days after receipt by the carrier.* [Emphasis added.]

Section 10-16-106.5, C.R.S., Prompt payment of claims – legislative declaration, states in part:

(5)(b) *A carrier that fails to pay, deny, or settle a claim in accordance with subsection (4) of this section within ninety days after receiving the claim shall pay to the insured or health care provider, with proper assignment, a penalty in an amount equal to twenty percent* of the total amount ultimately allowed on the claim. Such penalty shall be imposed on the ninety-first day after receipt of the claim by the carrier….* [Emphasis added.]

*Note that this penalty was ten percent until it was increased to twenty percent per statute. See L. 2008: (5)(b) amended, p 2174, § 7, effective August 5, 2008.

Over Ninety (90) Day Claims – Penalties

Population	Sample Size	Number of Exceptions	Percentage to Sample
1,174	107	7	7%

The examiner reviewed a random sample of 107 claims selected from a total population of 1,174 claims that were paid, denied or settled in excess of ninety (90) days during the period under examination.

Upon review of the 107 claims settled in over ninety (90) calendar days, the examiners determined that the Company did not appear to be in compliance with Colorado insurance law in that it failed to pay the penalty payment on the ninety-first (91^{st}) day in seven (7) instances. The penalty that should have been paid is ten percent (10%) for all violations that occurred prior to August 5, 2008 and twenty percent (20%) for all violations that occurred on or after August 5, 2008, on the total amount ultimately allowed on the claim, to the insured or health care provider.

<u>Recommendation No. 35:</u>

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-106.5, C.R.S. In the event the Company is unable to provide such documentation, it should provide evidence to the Division that it has established procedures to ensure that late payment penalties are paid as required by Colorado insurance law. The Company should also be required to conduct a self-audit to identify and correct any claims in which payments may have incorrectly failed to include the indicated penalty, from January 1, 2008 to the present.

Issue J3: Failure, in some cases, to request specific additional information when the carrier's claim liability cannot be determined with the existing information on the claim form, and the information requested would likely allow determination of liability to be made.

Section 10-16-106.5, C.R.S., Prompt payment of claims – legislative declaration, states in part:

(4)(b) *If the resolution of a claim requires additional information, the carrier shall, within thirty calendar days after receipt of the claim, give the provider, policyholder, insured, or patient, as appropriate, a full explanation in writing of what additional information is needed to resolve the claim, including any additional medical or other information related to the claim.* The person receiving a request for such additional information shall submit all additional information requested by the carrier within thirty calendar days after receipt of such request. Notwithstanding any provision of an indemnity policy to the contrary, the carrier may deny a claim if a provider receives a request for additional information and fails to timely submit additional information requested under this paragraph (b), subject to resubmittal of the claim or the appeals process. If such person has provided all such additional information necessary to resolve the claim, the claim shall be paid, denied, or settled by the carrier within the applicable time period set forth in paragraph (c) of this subsection (4). [Emphasis added.]

Colorado Insurance Regulation 4-2-24, Concerning Clean Claim Requirements for Health Carriers, states in part:

Section 6 Additional Information

A. A claim with all required fields, is not considered "clean" if additional information is needed in order to adjudicate the claim. *Carriers may request additional information only if the carrier's claim liability cannot be determined with the existing information on the claim form and the information requested is likely to allow determination of liability to be made. When additional information is required, the carrier shall make the specific request in writing* within thirty calendar days after receipt of the claim form. If information is being requested from a party other than the billing provider, the provider shall be notified that additional information is needed to adjudicate the claim. *The specific information requested shall be requested within 30 calendar days after receipt of the claim form and identified for the provider upon request.* [Emphases added.]

PAID CLAIMS

Population	Sample Size	Number of Exceptions	Percentage to Sample
60,367	109	9	8%

DENIED CLAIMS

Population	Sample Size	Number of Exceptions	Percentage to Sample
16,780	109	10	9%

It appears the Company is not in compliance with Colorado insurance law in that nine (9) of 109 paid claims randomly selected from the total population of 60,367 claims paid, and ten (10) of 109 denied claims randomly selected from a population of 16,780 claims denied, appeared to be unclean claims for which the Company requested non-specific medical information that was not necessarily related to the adjudication of the claim. In all of the cited files, the Company requested medical information for any and all conditions from the provider. For example:

> "Would you please sign, date and return this letter, along with the following:
>
> 1. A case history of all care provided since date first seen to present. Please show initial date(s) of pathogenesis, onset, treatment and any previous difficulty experienced with this or similar problems.
> 2. A resume' of past medical care for any health impairments, showing the conditions treated and dates of care.
> 3. A list of medications prescribed, indicating for each medication its name, the date it was first prescribed and the condition for which it was prescribed.
> 4. The heath history you have obtained from this patient, including the name and addresses of other attending/referring physicians."

None of the files contained any documentation that a written request for additional information and/or explanation of what additional specific information was needed to adjudicate the claim was sent to the provider, and/or the member for the sampled claim.

Recommendation No. 36:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-106.5, C.R.S. and Colorado Insurance Regulation 4-2-24. In the event the Company is unable to provide such documentation, it should provide evidence to the Division that it has established procedures to ensure that a written request for any additional specific information needed to resolve a claim, including any additional medical or other information related to the claim, is requested of the provider and/or the member in accordance with Colorado insurance law.

UTILIZATION REVIEW

Issue K1: Failure to include correct information in utilization review approval letters.

Section 10-16-704, C.R.S., Network adequacy – rules – legislative declaration - repeal, states in part:

> (4) *When a treatment or procedure has been preauthorized by the plan, benefits cannot be retrospectively denied except for fraud and abuse.* If a health carrier provides preauthorization for treatment or procedures that are not covered benefits under the plan, the carrier shall provide the benefits as authorized with no penalty to the covered person. [Emphasis added.]

Colorado Division of Insurance Bulletin B-4.13, Preauthorization for Treatments or Procedures by Health Plans, states in part:

> I. Background and Purpose
>
> …
>
> Carriers often contract with a third party to perform medical necessity or utilization review. The results of these reviews are often provided to the insureds or their providers before the carrier has made its coverage determination. In an attempt to reserve the right to make a subsequent coverage determination, the initial notification sometimes contains disclaimer language stating that coverage is contingent upon a subsequent level of review. After notification of approval at the initial review for medical necessity, some carriers are later denying coverage for the treatment or procedure which was the subject of the initial approval.
>
> …
>
> III. Division Position
>
> Colorado law states that once a carrier has "preauthorized" a treatment or procedure, the carrier cannot retrospectively deny the treatment or procedure, except for fraud and abuse, even where the benefit is not covered under the plan. See § 10-16-704(4), C.R.S. In addition, the statute prohibits the carrier from imposing a penalty on the covered person for coverage of the benefit where the treatment or procedure was preauthorized. Covered persons and providers often do not distinguish between a medical necessity determination and a coverage determination, and act upon the initial medical necessity determination alone.
>
> *To avoid any confusion between the types of determination, the Division interprets this statute to mean that whenever a treatment or procedure is approved, irrespective of the terminology used by the carrier when reviewing the claim (e.g., precertification, preauthorization, prior authorization, medical necessity, or utilization review), the carrier cannot subsequently deny coverage. In other words, it is incumbent upon the carrier to make its coverage determination prior to the delivery of any medical necessity determination* or other form of preauthorization to the covered person or their provider. The exceptions are for fraud and abuse, or where the covered person loses coverage

> after approval, but before actually obtaining the treatment or procedure. In addition, the carrier cannot reduce the benefit which was subject to the initial review in any manner, such as by requiring the insured to pay a higher co-pay than would normally be due under the plan.
>
> *Carriers cannot avoid the statutory requirement by including a disclaimer in the notice initially approving the treatment or procedure.* For example, a carrier cannot notify a provider and or covered person that a particular treatment or procedure has passed a certain level of review, but final approval is contingent upon additional review. To do so is a violation of the intent of the statute to prohibit retrospective denials after "preauthorization." [Emphases added.]

APPROVED DECISIONS – WRITTEN CONFIRMATION

Population	Sample Size	Number of Exceptions	Percentage to Sample
42	42	42	100%

The Examiner reviewed the entire population of forty-two (42) utilization review approvals made during the examination period. It appears that in all forty-two (42) instances the Company was not in compliance with Colorado insurance law in that the written confirmation provided to the provider and/or covered person indicates that the claim may be retrospectively denied for reasons other than those provided for in § 10-16-704(4) C.R.S. The written confirmations sent on behalf of World Insurance Company state, in part, the following:

> We have authorized a request for medical necessity received on 1/1/2008.
>
> This authorization is based on the information provided. You must call the Medical Management Department and re-certify this service if **any** [Emphasis in original] of the information changes. If you need additional services following the services authorized above, you or your provider must call the Medical Management Department at the toll free number below.
>
> This authorization reflects a determination that the services described above are medically necessary. *It does not guarantee payment of benefits under your plan.* For example, if your coverage is not in effect at the time of service, you may be fully responsible for all charges. Please review the sections on eligibility, benefits and coverage your plan booklet. Notwithstanding the above, applicable state law may require the payment of benefits.
>
> *This determination does not certify the medical necessity of all of the services related to the service described above.* For example, if you have been approved for surgery, an assistant surgeon or surgical assistant may not be considered medically necessary. Please have your surgeon verify the necessity of an assistant before proceeding.
>
> If the provider and/or the facility are not included in your plannetwork, [sic] you may be fully responsible for all non-network charges unless your plan has an out-of-network benefit. If your plan has an out-of-network benefit, services will be paid in accordance with that benefit. *Additionally, you may not be able to choose some of the providers that render services to you.*
>
> *For example, you may not be able to choose the radiologist who reads your x-ray and the radiologist may not be in your network. Please refer to your plan booklet or call our Customer Service Department to determine coverage for this type of provider along with verifying the network status of any of your providers and/or facilities."* [Emphases added.]

Recommendation No. 37:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-704, C.R.S. In the event the Company is unable to provide such documentation, it should provide evidence to the Division that it has established procedures to ensure that its coverage determination is made prior to the delivery of any medical necessity determination. The Company should also provide evidence that after notification of approval occurring after the initial review for medical necessity, there is no retrospective denial of the treatment of a procedure (except for fraud and abuse). Additionally, the Company should also be required to conduct a self-audit to identify and correct any claims that may have been incorrectly denied due to this incorrect language, from January 1, 2008 to the present

SUMMARY OF ISSUES AND RECOMMENDATIONS

ISSUES		Rec. No.	Page No.
CONTRACT FORMS – FINDINGS			
Issue E1:	**Failure to provide coverage to or on behalf of an insured because the insured or a covered dependent sustained an injury while intoxicated or under the influence of a controlled substance.**	1	18
Issue E2:	**Failure, in some cases, to include or to completely include the required language related to contract changes within the Company's policy forms.**	2	21
Issue E3:	**Failure, in some cases, to include the required one year timeframe regarding time limits on certain defenses.**	3	24
Issue E4:	**Failure, in some cases, to include the mandatory language related to notice of claim.**	4	26
Issue E5:	**Failure, in some cases, to include the mandatory language related to payment of claims.**	5	28
Issue E6:	**Failure, in some cases, to include the mandatory language related to change of beneficiary.**	6	30
Issue E7:	**Failure, in some cases, to include the mandatory language related to early intervention services.**	7	31
Issue E8:	**Failure, in some cases, to provide complete benefits related to therapies for congenital defects and birth abnormalities.**	8	33
Issue E9:	**Failure, in some cases, to provide coverage to stepchildren that do not permanently reside with an insured.**	9	35
Issue E10:	**Failure, in some cases, to include the mandatory coverage provision, or to provide the required number of number of well-child visits, related to child health supervision services.**	10	38
Issue E11:	**Failure, in some instances, to include the mandatory coverage for prosthetic devices.** *This appears to be a repeat issue that was identified as issue E8 during the last market conduct exam of this Company, which was completed on June 11, 2004 covering the period of January 1, 2003 to December 31, 2003.*	11	39
Issue E12:	**Failure, in some cases, to include the mandatory coverage for cervical cancer vaccines.**	12	40
Issue E13:	**Failure to offer coverage for dependents up to age twenty-five.**	13	42
Issue E14:	**Failure to include the required disclosure regarding coverage for treatment of intractable pain.**	14	43
Issue E15:	**Failure, in some cases, to include the appropriate definition of "Dependent" within the Company's policy forms.**	15	47
Issue E16:	**Failure, in some cases, to provide coverage for services and/or supplies furnished by a member of a covered person's immediate family, employer, business partner, or a person who ordinarily resides in the covered person's home.** *This appears to be a repeat issue that was identified as issue E7*	16	49

	ISSUES	**Rec. No.**	**Page No.**
	during the last market conduct exam of this Company, which was completed on June 11, 2004 covering the period of January 1, 2003 to December 31, 2003.		
Issue E17:	**Failure, in some cases, to include the appropriate definition of "preexisting condition" in the Company's forms.**	17	51
Issue E18:	**Failure, in some cases, to provide coverage for self-inflicted injuries, suicide, and attempted suicide to members that are insane.** *This appears to be a repeat issue that was identified as issue E5 during the last market conduct exam of this Company, which was completed on June 11, 2004 covering the period of January 1, 2003 to December 31, 2003.*	18	54
Issue E19:	**Failure, in some cases, to provide coverage for procedures that have been preauthorized.**	19	56
Issue E20:	**Failure, in some cases, to provide a clear indication of what is considered a complication of pregnancy and/or the complications of pregnancy definition included in the policy is overly restrictive.**	20	61
Issue E21:	**Failure to provide a complete listing of forms within its annual certification of forms.**	21	63
Issue E22:	**Failure to ensure that all forms certified by the Company were in compliance with Colorado insurance law.**	22	65
Issue E23:	**Failure, in some cases, to provide coverage to newborns or children placed for adoption for the first thirty-one (31) days from the date of birth or placement unless premium is paid.**	23	68
Issue E24:	**Failure, in some cases, to provide coverage related to any organ, system, or part/area of the body that the Company deems necessary.**	24	70
Issue E25:	**Failure, in some cases, to provide coverage for services or treatment related to certain "high risk" activities.**	25	71
Issue E26:	**Failure to specifically include the required coverage for newborn hospital stays.**	26	72
Issue E27:	**Failure, in some cases, to include the mandatory coverage for inherited enzymatic disorders.**	27	74
Issue E28:	**Failure, in some cases, to apply the appropriate timeframes related to when premium can be accepted in connection with a reinstatement, and to use the statutorily-mandated language as required.**	28	78
Issue E29:	**Failure, in some cases, to clearly disclose the existence and availability of an access plan.** *This appears to be a repeat issue that was identified as issue E4 during the last market conduct exam of this Company, which was completed on June 11, 2004 covering the period of January 1, 2003 to December 31, 2003.*	29	79
Issue E30:	**Failure, in some cases, to include the mandatory language regarding claim forms.**	30	80

ISSUES		Rec. No.	Page No.
Issue E31:	**Failure to reflect the appropriate adjustments that are to be made when a misstatement of age or sex occurs.**	31	82
Issue E32:	**Failure, in some cases, to include the mandatory coverage for hospitalization and general anesthesia for dental procedures for dependent children.**	32	84
Issue E33:	**Failure, in some cases, to include the mandatory coverage for diabetes.**	33	85
	CLAIMS – FINDINGS		
Issue J1:	**Failure, in some cases, to pay, deny or settle claims within the timeframes required by Colorado insurance law.**	34	88
Issue J2:	**Failure, in some cases, to pay the appropriate penalty payment to the insured or health care provider on the ninety-first day after receipt of the claim by the carrier.**	35	89
Issue J3:	**Failure, in some cases, to request specific additional information when the carrier's claim liability cannot be determined with the existing information on the claim form, and the information requested would likely allow determination of liability to be made.**	36	92
	UTILIZATION REVIEW – FINDINGS		
Issue K1:	**Failure to include correct information in utilization review approval letters.**	37	96

EXAMINATION REPORT SUBMISSION

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